OFFICE OF THE STATE CONTROLLER

STATE MANDATED COSTS CLAIMING INSTRUCTIONS NO. 2000-9

ANNUAL INSTRUCTIONS--SCHOOL DISTRICTS

September 29, 2000

Section 17561 of the Government Code provides for the reimbursement of state mandated costs. Enclosed is information for updating the Mandated Cost Manual for Schools. The manual contains all forms and instructions that are necessary for schools to file 2000-01 annual claims with the State Controller's Office.

Estimated claims for costs to be incurred during the 2000-01 fiscal year and reimbursement claims detailing the costs actually incurred in the 1999-00 fiscal year must be filed with the State Controller's Office. Claims must be delivered or postmarked on or before January 16, 2001. If the reimbursement claim is filed after the deadline, but by January 15, 2002, the approved claim will be reduced by a late penalty of 10%, not to exceed $1,000. In order for a claim to be considered properly filed, the claim must include supporting documentation as specified in the instructions to substantiate the costs claimed. In addition, the claimant must explain the functions performed by each employee for whom costs were claimed. Claims will not be accepted if filed more than one year after the deadline, or without supporting documentation.

Amounts appropriated for payment of program costs are shown on page 5 under "Appropriations for State Mandated Cost Programs—2000-01 Fiscal Year." The fiscal years for which costs can be claimed for a mandated cost program are shown on pages 6 and 7, under "Reimbursable State Mandated Costs Programs." To prepare 2000-01 estimated claims and 1999-00 reimbursement claims, forms in the manual should be duplicated to meet the district's filing requirements.

Claims should be rounded to the nearest dollar. For each program, submit a signed original and a copy of form FAM-27, and a copy of all other forms and supporting documents to:

Address, if delivery by:
U.S. Postal Service

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivery by:
Other delivery services

Office of the State Controller
Attn: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MINIMUM CLAIM COST

Government Code section 17564(a) provides that no claim or payment shall be made pursuant to section 17561 unless such a claim exceeds $200 per program per fiscal year. However, any county superintendent of schools, as fiscal agent for the district, may submit a combined claim in excess of $200 on behalf of the districts within the county, even if an individual district's claim

does not exceed $200. The combined claim must show the individual claim costs for each school district. Once a combined claim is filed, all subsequent fiscal years relating to the same mandate must be filed in a combined form. The county receives the reimbursement payment and is responsible for disbursing funds to each participating district. A school district may withdraw from the combined claim by providing a written notice to the county superintendent of schools and the State Controller's Office of its intent to file a separate claim at least 180 days prior to the deadline for filing the claim.

ESTIMATED CLAIMS

Unless otherwise specified in the claiming instructions, claimants do not have to provide cost schedules and supporting documents with the estimated claim if the estimated amount does not exceed the prior fiscal year's actual costs by more than 10%. The claimant can simply enter the estimated amount on form FAM-27, line (07). However, if the estimated claim exceeds the prior fiscal year's actual costs by more than 10%, the claimant must complete claim forms as specified for the program and explain the reason for increased costs. If the explanation to support the higher estimate is not provided with the claim, the claim will automatically be adjusted to 110% of the prior fiscal year's actual costs.

PROGRAM UPDATES FOR 2000-01 FISCAL YEAR

Ch. 486/75 Mandate Reimbursement Process

Ch. 486/75, Mandate Reimbursement Process, provides reimbursement for the cost of: (1) preparing and presenting successful test claims, and (2) preparing and submitting successful reimbursement claims to the State Controller's Office. With respect to preparing and submitting claims to the State Controller's Office, the 2000 State Budget Act (Chapter 52, Statutes of 2000), imposed in the 2000-01 fiscal year the same limitations as those imposed since the 1995-96 fiscal year. Limitations on reimbursement for independent contractor costs are as follows:

> "If a local agency or school district contracts with an independent contractor for the preparation and submission of reimbursement claims, the costs reimbursable by the state for that purpose shall not exceed the lesser of (1) 10 percent of the amount of the claims prepared and submitted by the independent contractor, or (2) the actual costs that would necessarily have been incurred for that purpose if performed by employees of the local agency or school district.
>
> The maximum amount of reimbursement provided (in the above provision) may be exceeded only if the local agency or school district establishes, by appropriate documentation, that the preparation and submission of these claims could not have been accomplished without the incurring of the additional costs claimed by the local agency or school district".

Updates of Rates and Factors

The following are rates to be used for filing 1999-00 reimbursement claims. The 1999-00 rates are computed by adjusting the 1998-99 rates by changes in the Implicit Price Deflator (IPD) as determined by the State Department of Finance's report of July 28, 2000, *Cost of Goods and Services to Governmental Agencies.* The estimated change in the IPD for 1999-00 is 3.7%. For preparing the 2000-01 estimated claims, districts may use the program's 1999-00 rate or increase the 1999-00 rate by the estimated 2000-01 IPD change of 2.8% to determine 2000-01 estimated claim amounts. In the subsequent fiscal year, the estimated amount must be adjusted to actual cost.

--*Ch. 448/75 Annual Parent Notification*

The 1999-00 unit rate is $0.0597 per page of printed notification material distributed to parents and guardians.

--*Ch. 961/75 Collective Bargaining*

The 1999-00 GNP Deflator factor for adjusting the 1974-75 Winton Act cost is 3.049.

--*Ch. 1177/76 Immunization Records*

The 1999-00 unit rate is $4.84 per new entrant (K-12). A new entrant does not include a student previously enrolled in a school within the State of California.

Payment of the cost of immunization records for 1992-93 and subsequent fiscal years are made pursuant to the State Mandates Apportionment System to those school districts with an established base year entitlement. An entitlement amount is determined by the State Controller's Office by averaging the district's actual costs [from reimbursement claims filed] for 1989-90, 1990-91, and 1991-92, or any three consecutive fiscal years thereafter, adjusted by changes in the IPD. The amount of apportionment the district receives for 1992-93 and subsequent fiscal years is the base year entitlement amount adjusted by annual changes in IPD and workload. "Workload" means change in the district's average daily attendance from the previous fiscal year.

Once the district has filed actual costs for 1989-90, 1990-91, and 1991-92, or any three consecutive fiscal years thereafter, no further filing of claims is necessary. The claimant will automatically receive an annual payment by November 30 of each fiscal year. A district without an established entitlement amount must continue to file reimbursement claims until three consecutive fiscal years of costs are available to compute a base year cost.

--*Ch. 668/78 Pupil Exclusions*

The 1999-00 unit cost reimbursement is $0.1749 per page for the cost of including specific information in the notice of pupil exclusion to the parents or guardian. The unit cost rate covers all costs (direct and indirect) of performing activities required by subparagraph (2), (3), and (4), of Education Code Section 48213.

--*Ch. 1347/80 Scoliosis Screening*

The 1999-00 unit cost reimbursement is $5.80 per student screened. The unit cost rate covers all costs (direct and indirect), incurred including activities for, but not limited to, parent notification, screening, re-screening, referral and follow-up, record keeping, and administration of the program.

--*Ch. 498/83 Notification of Truancy*

The 1999-00 unit cost reimbursement is $12.23 per initial truancy notification. The unit cost covers all costs (direct and indirect), including, but not limited to, identifying the truant pupil, preparing and distributing by mail or other methods of notification to parents/guardians, and associated record keeping.

--*Ch. 498/83 Increased Graduation Requirements*

The 1999-00 maximum reimbursement hourly rate for contract services is $104.58. Staffing cost reimbursement is limited to salary and other remuneration differentials, if any, of a science teacher, and the cost of lab assistants or special training aids required by a science class. The addition of science classes should have resulted in offsetting savings due to a corresponding reduction of non-science classes.

--*Ch. 1423/84 Juvenile Court Notices II*

The 1999-00 unit rates for the number of notices received from the juvenile court system and distributed to school district personnel is $33.80 per notice received, and the number of written request received from parents or guardian to review the record to ensure the record has been destroyed is $24.03 per letter received.

--*Ch. 87/86 Schoolsite Discipline Rules*

The 1998-99 unit reimbursement rates for school types are as follows:

Fiscal Years	Elementary Schools	Middle/ Junior High	High Schools	Other Schools
1999-00	$0.2332	$0.2916	$0.4082	$0.4082

FINAL FILING DEADLINE FOR 1998-99 FISCAL YEAR CLAIMS

The final filing deadline for 1998-99 reimbursement claims is January 16, 2001. A late penalty of 10% of the approved claim not to exceed $1,000 must be applied to 1998-99 claims filed after January 16, 2001. Claims filed after January 16, 2001, will not be accepted.

APPROPRIATIONS FOR STATE MANDATED COST PROGRAMS--2000-01 FISCAL YEAR

	Source of State Mandated Cost Appropriations		Programs	Amounts Appropriated
	Chapter 52/00, Item 6110-295-0001			
(1)	Chapter	448/75	Annual Parent Notification	$3,491,000
(2)	Chapter	77/78	Absentee Ballots	1,261,000
(3)	Chapter	87/86	School Discipline Rules	1,681,000
(4)	Chapter	98/94	Caregiver Affidavits	377,000
(5)	Chapter	160/93	School District of Choice	9,939,000
(6)	Chapter	134/87	Pupil Suspension: District Employee Reports	995,000
(7)	Chapter	161/93	Intradistrict Attendance	5,124,000
(8)	Chapter	172/86	Interdistrict Attendance	1,742,000
(9)	Chapter	172/86	Interdistrict Attendance: Parent's Employment	1,082,000
(10)	Chapter	486/75	Mandate Reimbursement Process	11,544,000
(11)	Chapter	498/83	Increased Graduation Requirements	13,533,000
(12)	Chapter	498/83	Notification of Truancy	7,765,000
(13)	Chapter	498/83	Pupil Expulsion/Expulsion Appeals	2.363,000
(14)	Chapter	624/92	School Bus Safety	913,000
(15)	Chapter	641/86	Open Meetings Act	3,306,000
(16)	Chapter	668/86	Pupil Exclusions	377,000
(17)	Chapter	781/92	Charter Schools	582,000
(18)	Chapter	783/95	Investment Reports	153,000
(19)	Chapter	799/80	PERS Increased Death Benefits	751,000[1]
(20)	Chapter	818/91	AIDS Prevention Instruction	3,036,000
(21)	Chapter	961/75	Collective Bargaining	39,466,000
(22)	Chapter	965/77	Pupil Classroom Suspension	1,747,000
(23)	Chapter	1208/76	Pupil Health Screenings	3,128,000
(24)	Chapter	975/95	Physical Performance Test	1,145,000
(25)	Chapter	1423/84	Juvenile Court Records II	327,000
(26)	Chapter	1107/84	Removal of Chemicals	1,268,000
(27)	Chapter	1117/89	Law Enforcement Agency Notification	1,470,000
(28)	Chapter	1176/77	Immunization Records	3,353,000
(29)	Chapter	1184/75	Habitual Truants	5,255,000
(30)	Chapter	1213/91	Collective Bargaining Agreement Disclosures	264,000
(31)	Chapter	1253/75	Expulsion Transcripts	27,000
(32)	Chapter	1284/88	Parent Classroom Visits	992,000
(33)	Chapter	1306/89	Notification to Teachers of Pupil Expulsion	2,778,000
(34)	Chapter	1347/80	Scoliosis Screening	2,183,000
(35)	Chapter	1398/74	PERS-Unused Sick Leave Credits	3,107,000 [1]
(36)	Chapter	1463/89	School Accountability Report Cards	2,059,000
(37)	Chapter	1607/84	School Crimes Reporting	1,516,000

[1]Funds appropriated in lines 19 and 35 are for transfer to the Public Employees' Retirement System for reimbursement of costs incurred pursuant to Chapter 799/80 and Chapter 1398/74.

APPROPRIATIONS FOR STATE MANDATED COST PROGRAMS--
2000-01 FISCAL YEAR (Continued)

Source of State Mandated Cost Appropriations		Programs	Amounts Appropriated
(29)	Chapter 1659/84	Emergency Procedures: Earthquake and Disasters	13,855,000
(30)	Chapter 1675/84	School Testing-Physical Fitness	662,000
	Total Appropriations, Item 6110-295-001		$154,617,000
Item 6870-295-0001			
	Chapter 1/84	Health Fee Elimination	1,691,000
TOTAL—Funding for the 2000-01 Fiscal Year			**$156,308,000**

REIMBURSABLE STATE MANDATED COST PROGRAMS

Claims for the following State mandated cost programs may be filed with the State Controller's Office. The "X"s indicate the fiscal year for which a claim may be filed.

1999-00 Reimbursement Claims	2000-01 Estimated Claims			
		School Districts and County Offices of Education		
x	x	Chapter	448/75	Annual Parent Notification
x	x	Chapter	486/75	Mandate Reimbursement Process
x	x	Chapter	961/75	Collective Bargaining
x	x	Chapter	1184/75	Habitual Truants
x	x	Chapter	1253/75	Expulsion Transcripts
x	x	Chapter	1253/75	Pupil Suspensions, Expulsions, and Expulsion Appeals
x	x	Chapter	1208/76	Pupil Health Screenings
x	x	Chapter	965/77	Pupil Classroom Suspension
x	x	Chapter	1176/77	Immunization Records
x	x	Chapter	77/78	Absentee Ballots
x	x	Chapter	668/78	Pupil Exclusions
x	x	Chapter	797/80	Special Education
x	x	Chapter	1347/80	Scoliosis Screening
x	x	Chapter	498/83	Increased Graduation Requirements
x	x	Chapter	498/83	Notification of Pupil Truancy
x	x	Chapter	1107/84	Removal of Chemicals
x	x	Chapter	1423/84	Juvenile Court Records II
x	x	Chapter	1600/84	School Crimes Reporting
x	x	Chapter	1659/84	Emergency Procedures: Earthquake and Disasters
x	x	Chapter	87/86	School Discipline Rules
x	x	Chapter	172/86	Interdistrict Attendance
x	x	Chapter	172/86	Interdistrict Attendance: Parent Employment

REIMBURSABLE STATE MANDATED COSTS PROGRAMS (continued)

1999-00 Reimbursement Claims	2000-01 Estimated Claims			
x	x	Chapter	641/86	Open Meetings Act
x	x	Chapter	1284/88	Parent Classroom Visits
x	x	Chapter	1117/89	Law Enforcement Agency Notification
x	x	Chapter	1306/89	Notification to Teacher: Pupil Expulsion
x	x	Chapter	1463/89	School Accountability Report Cards
x	x	Chapter	818/91	AIDS Prevention Instruction
x	x	Chapter	624/92	School Bus Safety II
x	x	Chapter	781/92	Charter Schools
x	x	Chapter	1249/92	Threats Against Peace Officers
x	x	Chapter	160/93	School District of Choice: Transfers and Appeals
x	x	Chapter	161/93	Intradistrict Attendance
x	x	Chapter	98/94	Caregiver Affidavits
x	x	Chapter	309/95	Pupil Residency Verification and Appeals
x	x	Chapter	783/95	Investment Reports
x	x	Chapter	975/95	Physical Performance Tests
x	x	Chapter	778/96	American Government Course Document Requirements
x	x	Chapter	588/97	Criminal Background Checks
				Community College Districts
x	x	Chapter	486/75	Mandate Reimbursement Process
x	x	Chapter	961/75	Collective Bargaining
x	x	Chapter	77/78	Absentee Ballots
x	x	Chapter	1/84	Health Fee Elimination
x	x	Chapter	641/86	Open Meetings Act
x	x	Chapter	1249/92	Threats Against Peace Officers
x	x	Chapter	783/95	Investment Reports

NEW CLAIMING INSTRUCTIONS ON THE HORIZON

Claiming instructions for the following mandated programs will be placed on the Controller's web site in the near future. The parameters and guidelines (P's & G's) for these programs have recently been adopted, or are pending adoption by the Commission on State Mandates. This office will place these instructions on the web site within 60 days of receiving the P's and G's from the Commission.

- Physical Education Report, Ch. 640/97
- Behavioral Intervention Plans, Ch. 959/90
- Standardized Testing and Reporting Test Claim, Ch. 828/97
- Immunization Records-Hepatitis, Ch. 325/78

AUDIT OF COSTS

All claims submitted to the State Controller's Office are reviewed to determine if costs are related to the mandate, costs are reasonable and not excessive, and the claim was prepared in accordance with the claiming instructions. If any adjustments are made to a claim, a "Notice of Claim Adjustment" will be mailed within 30 days after payment of the claim. The notice will specify the claim component adjusted, the amount adjusted, and the reason for the adjustment.

On-site audits will be conducted by the State Controller's Office as deemed necessary. Accordingly, documentation to support actual costs claimed must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended. Claim documentation shall be made available to the State Controller's Office on request.

RETENTION OF CLAIMING INSTRUCTIONS

Claiming instructions and forms in this package should be retained permanently in the School Mandated Cost Manual for future reference and use in filing claims. The forms should be duplicated to meet your filing requirements. Each year, the State Controller's Office will place on its web site **www.sco.ca.gov/ard/local/locreim/index/htm** updated forms and any other information or instructions claimants may need to file claims. Each vertical line next to the page margin indicates the place where a revision was made to the instructions or form. When the costs of a new program are claimable, instructions to claim these costs will be placed on the web site.

If you have any questions concerning mandated cost reimbursements, please write to us at the address listed for filing claims, e-mail to **gibrummels@sco.ca.gov**, or call the Local Reimbursements Section at (916) 323-3258.

SCHOOL MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
Table of Contents (Revised 10/99)	Table of Contents (Revised 9/00)
Ch. 448/75, Annual Parent Notification, form APN-1 (Revised 4/00)	Ch. 448/75, Annual Parent Notification, form APN-1 (Revised 9/00)
Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 4/96)	Ch. 486/75, Mandate Reimbursement Process, form FAM-27 (Revised 9/00)
Ch. 961/75, Collective Bargaining, forms FAM-27 and CB-1 (Revised 4/00)	Ch. 961/75, Collective Bargaining, forms FAM-27 and CB-1 (Revised 9/00)
Ch. 1184/75, Habitual Truants, form FAM-27 (New 4/98)	Ch. 1184/75, Habitual Truants, form FAM-27 (Revised 9/00)
Ch. 1253/75, Expulsion of Pupils: Transcripts, forms FAM-27 (Revised 10/95)	Ch. 1253/75, Expulsion OF Pupils: Transcripts, form FAM-27 (Revised 9/00)
Ch. 1253/75, Pupil Suspensions, Expulsions and Expulsion Appeals, all pages (Revised 10/98)	Ch. 1253/75, Pupil Suspensions, Expulsions and Expulsion Appeals, all pages (Revised 9/00)
Ch. 1208/76, Pupil Health Screenings, form FAM-27 (New 4/96)	Ch. 1208/76, Pupil Health Screenings, form FAM-27 (Revised 9/00)
Ch. 965/77, Pupil Classroom Suspension: Counseling, form FAM-27 (New 3/97)	Ch. 965/77, Pupil Classroom Suspension: Counseling, form FAM-27 (Revised 9/00)
Ch. 1176/77, Immunization Records, forms IR-1 (Revised 10/99), FAM-27 (Revised 10/96)	Ch. 1176/77, Immunization Records, forms IR-1, FAM-27 (Revised 9/00)
Ch. 77/78, Absentee Ballots, form FAM-27 (New 2/98)	Ch. 77/78, Absentee Ballots, form FAM-27 (Revised 9/00)
Ch. 668/78, Pupil Exclusions, forms PE-2.1 (Revised 10/99) and FAM-27 (New 4/98)	Ch. 668/78, Pupil Exclusions, forms PE-2.1 and FAM-27 (Revised 9/00)
Ch. 1347/80, Physical Examination for Scoliosis, forms PES-1 (Revised 10/99) and FAM-27 (Revised 1/99)	Ch. 1347/80, Physical Examination for Scoliosis, forms PES-1and FAM-27 (Revised 9/00)
Ch. 498/83, Increased Graduation Requirements, forms GR-2 (Revised 10/99) and FAM-27 (Revised 10/95)	Ch. 498/83, Increased Graduation Requirements, forms GR-2 and FAM-27 (Revised 9/00)
Ch. 498/83, Notification of Pupil Truancy, forms FAM-27and NOT-1(Revised 10/95)	Ch. 498/83, Notification of Pupil Truancy, forms FAM-27 and NOT-1 (Revised 9/00)
Ch. 1/84, Health Fee Elimination, form FAM-27 (Revised 9/97)	Ch. 1/84, Health Fee Elimination, form FAM-27 (Revised 9/00)

SCHOOL MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
Ch. 1107/84, Removal of Chemical, form FAM-27 (Revised 10/95)	Ch. 1107/84, Removal of Chemical, form FAM-27 (Revised 9/00)
Ch. 1423/84, Juvenile Court Records II, all pages (Revised 3/97)	Ch. 1423/84, Juvenile Court Records II, all pages (Revised 9/00)
Ch. 1600/84, School Crimes Statistics Reporting and Validation, form FAM-27 (Revised 1/99)	Ch. 1600/84, School Crimes Statistics Reporting and Validation, form FAM-27 (Revised 9/00)
Ch. 1659/84, Emergency Procedures: Earthquake and Disasters, form FAM-27 (Revised 10/95)	Ch. 1659/84, Emergency Procedures: Earthquake and Disasters, form FAM-27 (Revised 9/00)
Ch. 87/86, School Discipline Rules, forms SDR-1 (Revised 10/99) FAM-27 (New 3/97)	Ch. 87/86, School Discipline Rules, forms SDR-1 and FAM-27 (Revised 9/00)
Ch. 172/86, Interdistrict Attendance Permits, form FAM-27 (New 3/97)	Ch. 172/86, Interdistrict Attendance Permits, form FAM-27 (Revised 9/00)
Ch. 172/86, Interdistrict Attendance: Parent's Employment, form FAM-27 (New 6/97)	Ch. 172/86, Interdistrict Attendance: Parent's Employment, form FAM-27 (Revised 9/00)
Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 10/95)	Ch. 641/86, Open Meetings Act, form FAM-27 (Revised 9/00)
Ch. 1284/88, Parent Classroom Visits, form FAM-27 (New 3/97)	Ch. 1284/88, Parent Classroom Visits, form FAM-27 (Revised 9/00)
Ch. 1117/89, Law Enforcement Agency Notification, form FAM-27 (New 3/97)	Ch. 1117/89, Law Enforcement Agency Notification, form FAM-27 (Revised 9/00)
Ch. 1306/89, Notifications to Teachers: Pupil Expulsion, form FAM-27 (New 3/97)	Ch. 1306/89, Notifications to Teachers: Pupil Expulsion, form FAM-27 (Revised 9/00)
Ch. 1463/89, School Accountability Report Cards, all pages (Revised 10/98)	Ch. 1463/89, School Accountability Report Cards, all pages (Revised 9/00)
Ch. 818/91, AIDS Prevention Instruction, form FAM-27 (Revised 9/97)	Ch. 818/91, AIDS Prevention Instruction, form FAM-27 (Revised 9/00)
Ch. 781/92, Charter Schools, form FAM-27 (New 4/96)	Ch. 781/92, Charter Schools, form FAM-27 (Revised 9/00)
Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (New 5/98)	Ch. 1249/92, Threats Against Peace Officers, form FAM-27 (Revised 9/00)
Ch. 160/93, School District of Choice: Transfer and Appeals, form FAM-27 (New 3/97)	Ch. 160/93, School District of Choice: Transfer and Appeals, form FAM-27 (Revised 9/00)
Ch. 161/93, Intradistrict Attendance, form FAM-27 (New 3/97)	Ch. 161/93, Intradistrict Attendance, form FAM-27 (Revised 9/00)

SCHOOL MANDATED COST MANUALS
REVISIONS
SEPTEMBER 2000

REMOVE	INSERT
Ch. 98/94, Caregiver Affidavits, all pages (New 10/98)	Ch. 98/94, Caregiver Affidavits, all pages (Revised 9/00)
Ch. 783/95, Investment Reports, form FAM-27 (New 1/98)	Ch. 783/95, Investment Reports, form FAM-27 (Revised 9/00)
Ch. 975/95, Physical Performance Tests, form FAM-27 (New 12/98)	Ch. 975/95, Physical Performance Tests, form FAM-27 (Revised 9/00)
Ch. 778/96, American Government Course Document Requirements, form FAM-27 (New 4/99)	Ch. 778/96, American Government Course Document Requirements, form FAM-27 (Revised 9/00)
	Appendix B, page 5 (New 9/00)

TABLE OF CONTENTS

MANDATED COSTS **ANNUAL PARENT NOTIFICATION** **CLAIM SUMMARY**	**FORM** **APN-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

(03) Uniform Cost Allowance: Indicate the following for the fiscal year of claim

	(a) Per Page Reimbursement Rate	(b) Specified Number of Pages	(c) Sets Distributed or ADE or ADA	(d) Total (a) x (b) x (c)
(04) Total Cost				

Cost Reduction	
(05) Less: Offsetting Savings	
(06) Less: Other Reimbursements	
(07) Total Claimed Amount [Line (04)(d) – {Line (05) + Line (06)}]	

ANNUAL PARENT NOTIFICATION CLAIM SUMMARY Instructions	**FORM APN-1**

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

From APN-1 must be filed for a reimbursement claim. Do not complete form APN-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form APN-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (a) Enter the unit rate per page for reimbursement of the cost of the annual parent notification/application from the rates listed below.

Fiscal Years	Unit Rate Per Page
1992-93	$ 0.0500
1993-94	0.0500
1994-95	0.0512
1995-96	0.0527
1996-97	0.0541
1997-98	0.0561
1998-99	0.0571
1999-00	0.0597
2000-01	0.0614 (Estimated)

(b) For claims due on August 3, 2000, only costs for Section 48980 (c) and (h) may be claimed. Using the table on page 5, enter the number of claimable pages. For the 1997-98 claim, enter 1.5 pages on line (03)(b). For the 1998-99 fiscal year, enter 1.5 or 3.5 claimable pages as applicable, on line (03)(b). The difference is because Section 48980(h) does not apply to all school districts.

For annual claims due on January 15, enter the specified pages from the table on page 5 of the text for the fiscal year of claim.

(c) Enter the number of sets of notifications/applications or the actual district enrollment (ADE) at the time of distribution or the district's annual average daily attendance (ADA).

(d) Leave blank.

(04) Enter the product of column (a) times (b) times (c).

(05) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(06) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, that reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(07) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (05), and Other Reimbursements, line (06), from Total Cost, line (04)(d). Enter the remainder of this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
MANDATE REIMBURSEMENT PROCESS

For State Controller Use Only

(19) Program Number 00042
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) MRP-1, (03)(a)	
(23) MRP-1, (03)(b)	
(24) MRP-1, (03)(c)	
(25) MRP-1, (04)(1)(d)	
(26) MRP-1, (04)(2)(d)	
(27) MRP-1, (04)(3)(d)	
(28) MRP-1, (06)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code Section 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 486, Statutes of 1975, and Chapter 1459, Statutes of 1984, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 486, Statutes of 1975, and Chapter 1459, Statutes of 1984.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 486, Statutes of 1975, and Chapter 1459, Statutes of 1984, set forth on the attached statements.

Signature of Authorized Officer _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

MANDATE REIMBURSEMENT PROCESS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Use mailing label or leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete forms MRP-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from forms MRP-1, line (11)..

(14) If a reimbursement claim is filed after January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and an estimated claim was previously filed for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (28) for the reimbursement claim e.g. MRP-1, (03)(a), means the information is located on form MRP-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect cost percentage should be shown as a whole number and without the percentage symbol (i.e. 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
COLLECTIVE BARGAINING

For State Controller Use Only

(19) Program Number 00011
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	CB-1, (03)(1)(e)	
(23)	CB-1, (03)(2)(e)	
(24)	CB-1, (03)(3)(e)	
(25)	CB-1, (03)(4)(e)	
(26)	CB-1, (03)(5)(e)	
(27)	CB-1, (03)(6)(e)	
(28)	CB-1, (03)(7)(e)	
(29)	CB-1, (04)(d)	
(30)	CB-1, (04)(e)	
(31)	CB-1, (05)(e)	
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 961, Statutes of 1975 and Chapter 1213, Statutes of 1991; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 961, Statutes of 1975 and Chapter 1213, Statutes of 1991.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 961, Statutes of 1975 and Chapter 1213, Statutes of 1991, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

COLLECTIVE BARGAINING Certification Claim Form Instructions	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CB-1 and enter the amount from line (16).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CB-1, line (16). If more than one CB-1 is completed due to multiple department involvement in this mandate, add line (16) of each form CB-1.

(14) Filing Deadline. Amended Claims of Ch. 961/75 and Ch. 1213/91. If the reimbursement claim for fiscal year 1998-99, is filed after August 3, 2000, the claim must be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

In subsequent years, reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (31) for the reimbursement claim [e.g. CB-1, (03)(1)(e), means the information is located on form CB-1, line (03)(1), column (e)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS COLLECTIVE BARGAINING CLAIM SUMMARY	**FORM CB-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

Rodda Act Direct Costs	**Cost Elements**				
(03) Reimbursable Components	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Travel	(d) Contract Services	(e) Total
1. Determining Bargaining Units and Exclusive Representation					
2. Election of Unit Representation					
3. Cost of Negotiations					
4. Impasse Proceedings					
5. Collective Bargaining Agreement Disclosure					
6. Contract Administration					
7. Unfair Labor Practice Charges					
(04) Total Rodda Act Direct Costs					
Winton Act Direct Costs					
(05) Base Year, 1974-75 Direct Costs					

(06) Base Year Direct Costs Adjusted by IPD	[Line (05)(e) x 3.049] for 1999-00 F.Y.]	
(07) **Increased Direct Costs**	[Line (04)(e) – line (06)]	
Indirect Costs		
(08) Total Rodda Act Direct Costs less Contract Services	[Line (04)(e) – line (04)(d)]	
(09) Base Year Costs less Contract Services adjusted by IPD	[{Line (05)(e) - Line (05)(d) x 3.049]	
(10) Increased Direct Costs less Contract Services	[Line (08) - Line (09)]	
(11) Indirect Cost Rate	From J-380, J-580 or FAM-27C	%
(12) Increased Indirect Costs	[Line (10) x line (11)]	
(13) **Total Increased Direct and Indirect Costs**	[Line (07) + line (12)]	
Cost Reduction		
(14) Less: Offsetting Savings		
(15) Less: Other Reimbursements		
(16) Total Claimed Amount	[Line (13) – {Line (14) + line (15)}]	

COLLECTIVE BARGAINING CLAIM SUMMARY Instructions	**FORM CB-1**

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

From CB-1 must be filed for a reimbursement claim. Do not complete form CB-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form CB-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) For each of the reimbursable components, enter the total allowable cost from form CB-2, line (05), columns (d) through (g) onto form CB-1, block (03), lines (1) through (7), columns (a) through (d). Total each line and enter in column (e).

(04) Add columns (03)(d) and (e) for Cost Elements, and enter the totals on this line.

(05) Method A. Enter the 1974-75 Winton Act (base year) costs on line (05)(e). Enter on line (05)(d) any contract service costs included in line (05)(e).

Method B. Enter the amount from form CB-1.1, line (04)(b) onto line (05)(e). Enter on line (05)(d) any contract service costs included in line (05)(e).

(06) Method A. Multiply the base year cost on line (05)(e) by the implicit price deflator (IPD). The 1999-00 IPD is 3.049.

Method B. Enter the amount from form CB-1.1, line (04)(d).

(07) Subtract the Base Year Direct Costs Adjusted by the IPD, line (06), from Total Rodda Act Direct Cost, line (04)(e).

(08) Subtract Total Contract Services, line (04)(d), from Total Rodda Act Direct Costs, line (04)(e).

(09) Subtract Base Year Contract Services, line (05)(d), from Base Year, 1974-75 Direct Costs, line (05)(e), and multiply the remainder by the IPD.

(10) Subtract Base Year Costs less Contract Services adjusted by the IPD, line (09), from Total Rodda Act Direct Costs less Contract Services, line (08).

(11) Enter the indirect cost rate. School districts (K-12) may compute the amount of indirect costs to claim by multiplying their total direct costs by the State Department of Education forms J-380 or J-580 rate applicable to the fiscal year of costs. Community college districts may use the federally approved OMB A-21 rate, or the rate computed using form FAM-29C.

(12) Multiply Incremental Direct Costs less Contract Services, line (10), by Indirect Cost Rate, line (11).

(13) Enter the sum of Incremental Costs, line (07), and Incremental Indirect Costs, line (12).

(14) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(15) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(16) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
HABITUAL TRUANT

For State Controller Use Only

(19) Program Number 00166
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) HT-1, (03)	
(23) HT-1, (04)(1)(d)	
(24) HT-1, (04)(2)(d)	
(25) HT-1, (04)(3)(d)	
(26) HT-1, (04)(4)(d)	
(27) HT-1, (06)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code Section 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1184, Statutes of 1975, and Chapter 1023, Statutes of 1994, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1184, Statutes of 1975, and Chapter 1023, Statutes of 1994.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1184, Statutes of 1975, and Chapter 1023. Statutes of 1994, set forth on the attached statements.

Signature of Authorized Officer _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

HABITUAL TRUANT **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Use mailing label or leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete forms HT-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of the reimbursement claim from forms HT-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and an estimated claim was previously filed for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (27) for the reimbursement claim e.g. HT-1, (03), means the information is located on form HT-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
EXPULSION OF PUPILS: TRANSCRIPTS

For State Controller Use Only

(19) Program Number 00091
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) EOP-1, (03)	
(23) EOP-1, (04)(1)	
(24) EOP-1, (04)(2)	
(25) EOP-1, (06)(c)	
(26) EOP-1, (07)	
(27) EOP-1, (12)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1253, Statutes of 1975, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1253, Statutes of 1975.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1253, Statutes of 1975, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

EXPULSION OF PUPILS: TRANSCRIPTS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form EOP-1 and enter the amount from line (12).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form EOP-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and an estimated claim was previously filed for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (27) for the reimbursement claim e.g. EOP-1, (04)(1), means the information is located on form EOP-1, line (04), column (1). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

PUPIL SUSPENSIONS, EXPULSIONS, AND EXPULSION APPEALS

Summary of Legislation Pertaining to the Consolidation of Pupil Suspensions from School, Pupil Exclusions from School, and Pupil Expulsion Appeals

Pupil Suspensions from School
Education Code § 48911, subdivisions (b) and (e)
Chapter 965, Statutes of 1977, Chapter 668, Statutes of 1978,
Chapter 73, Statutes of 1980, Chapter 498, Statutes of 1983,
Chapter 856, Statutes of 1985, and Chapter 134, Statutes of 1987

Pupil Expulsions from School
Education Code § § 48915, subdivisions (a) and (b), 48915.1, 48915.2, 48916, and 48918
Chapter 1253, Statutes of 1975, Chapter 965, Statutes of 1977,
Chapter 668, Statutes of 1978, Chapter 318, Statutes of 1982, Chapter 498, Statutes of1983,
Chapter 622, Statutes of 1984, Chapter 942, Statutes of 1987, Chapter 1231, Statutes of 1990,
Chapter 152, Statutes of 1992, Chapter 1255, Statutes of 1993,
Chapter 1256, Statutes of 1993, Chapter 1257, Statutes of 1993, and
Chapter 146, Statutes of 1994

Pupil Expulsion Appeals
Education Code § § 48919, 48921-48924
Chapter 1253, Statutes of 1975, Chapter 965, Statutes of 1977,
Chapter 668, Statutes of 1978, and Chapter 498, Statutes of 1983

1. Summary of the Source of the Mandates

A. Pupil Suspensions from School

Education Code section 48903, subdivision (b), as added by Chapter 965, Statutes of 1977, and amended by Chapter 668, Statutes of 1978, and Chapter 73, Statutes of 1980, imposed a new requirement for the teacher or supervisor who referred the pupil to the principal for suspension from school to participate in the pre-suspension conference between the pupil and the principal (or the principal's designee as defined in Chapter 856, Statutes of 1985) whenever practical. "School employee" was added to the list of potential participants in the pre-suspension conference. Education Code section 48903 was repealed by Chapter 498, Statutes of 1983, and substantially the same requirements were moved to new Education Code section 48911, subdivision (b). The 1983 amendment authorized the school superintendent to suspend pupils from school and to conduct the informal conference.

Education Code section 48911, subdivision (e), as added and amended by Chapter 134, Statutes of 1987, requires a school district employee to report the cause of a pupil's suspension to the school district governing board or superintendent.

Education Code section 48915 subdivision (b), as amended by Chapter 1255, Statutes of 1993, requires that the principal or superintendent of a school district immediately suspend any pupil found to be in possession of a firearm, knife of no reasonable use to the pupil, or explosive at school or at a school activity off school grounds.

Education Code section 48918, subdivision (b), as amended by Chapter 1256, Statutes of 1993, limits the requirement for immediate suspension to "any pupil found to be in possession of a firearm at school or at a school activity off school grounds."

B. Pupil Expulsions

Education Code section 48915, subdivisions (a) and (b), as added by Chapter 498, Statutes of 1983, and amended by Chapters 1255 and 1256, Statutes of 1993, requires school district principals and superintendents to recommend expulsion of pupils to their governing boards if the pupil committed one of the following offenses:

(1) Causing serious physical injury to another person, except in self defense;

(2) Possession of any firearm, knife, explosive, or other dangerous device of no reasonable use to the pupil at school or at a school activity off school grounds;

(3) Unlawful sale of any controlled substance listed in Chapter 2 (commencing with section 11053) of Division 10 of the Health and Safety Code, except for the first offense for the sale of not more than one avoirdupois ounce of marijuana, other than concentrated cannabis;

(4) Robbery or extortion.

Education Code section 48915 as amended by Chapter 1255, Statutes of 1993, requires governing boards to either expel or recommend admission to an alternative education program if a pupil was found to be in possession of a firearm, knife of no reasonable use to the pupil, or explosive at school or at a school activity off school grounds. This provision was in effect from October 11, 1993 through December 31, 1993.

Education Code section 48915, subdivision (b), as amended by Chapter 1256, Statutes of 1993, limits expulsion or recommendation of an alternative education program to any pupil in possession of a firearm at school or at a school activity off school grounds. This provision became effective January 1, 1994.

Education Code section 48918, as added or amended by Chapter 1253, Statutes of 1975, Chapter 965, Statutes of 1977, Chapter 668, Statutes of 1978, Chapter 318, Statutes of 1982, Chapter 498, Statutes of 1983, Chapter 1231, Statutes of 1990, and Chapter 146, Statutes of 1994, requires school district governing boards to adopt rules and regulations for the expulsion of pupils, which must include the specific procedures set forth in section 48918.

Education Code section 48918, subdivision (b), as added or amended by Chapter 1253, Statutes of 1975, Chapter 965, Statutes of 1977, and Chapter 1231, Statutes of 1990, requires school districts to include in the written expulsion hearing notice to the pupil and the pupil's parent or guardian:

(1) A copy of the disciplinary rules of the district that relate to the alleged violation;

(2) Notice of the parent's, guardian's, or pupil's obligation pursuant to Education Code section 48915.1, subdivision (b), upon the pupil's enrollment in a new school district, to inform that district of the expulsion; and

(3) Notice of the right of the pupil or pupil's parent or guardian to inspect and copies of all documents to be used at the expulsion hearing.

Education Code section 48918, subdivision (i), as added or amended by Chapter 1253, Statutes of 1975, and Chapter 1231, Statutes of 1990, requires school districts to send to the pupil or the pupil's parent or guardian:

(1) Written notice of any decision to expel or suspend enforcement of an expulsion order during a period of probation;

(2) Notice of the right to appeal the expulsion to the county board of education; and

(3) Notice of the parent's, guardian's, or pupil's obligation pursuant to Education Code section 48915.1, subdivision (b), upon the pupil's enrollment in a new school district of the expulsion.

Education Code section 48914, subdivision (g), as amended by Chapter 965, Statutes of 1977, requires the governing board to maintain a record of each expulsion, including the cause thereof.

This provision was moved to new Education Code section 48915, subdivision (j), by Chapter 498, Statutes of 1983, which requires that the expulsion order and the causes thereof be recorded in the pupil's mandatory interim record and that this record be forwarded, upon request, to any school in which the pupil subsequently enrolls.

Education Code section 48916, as added by Chapter 498, Statutes of 1983, imposed a new requirement for school district governing boards to set a date, not later than the last day of the semester following the semester in which the expulsion occurred, when an expelled pupil may apply for re-admission. Section 48916 also requires school districts to adopt rules and regulations for the re-admission procedure, and to make these rules and regulations available to the pupil and the pupil's parent or guardian when the expulsion order is entered.

Education Code section 48915.1, as added by Chapter 942, Statutes of 1987, imposed a new requirement that school boards conduct a hearing if a pupil who was expelled from another school district poses a continuing threat to the school district's pupils or employees. This section also requires the expelling school district to respond to a request for information regarding a recommendation for expulsion by the receiving school district. Chapter 1231, Statutes of 1990, and Chapter 1257, Statutes of 1993, amended Education Code section 48915.1 and Chapter 1257, Statutes of 1993, moved the hearing requirements for pupils expelled for certain offenses from Education Code section 48915.1 to section 48915.2.

C. Pupil Expulsion Appeals

Education Code sections 48919 through 48924 as added by Chapter 498, Statutes of 1983, require county boards of education to: Adopt rules and regulations establishing procedures for expulsion appeals; notify persons of the requirements for filing the appeal, notify the parties of the acceptance of the filed appeal, the date of the hearing, the requirement for the appellant to provide a transcript of the school district expulsion hearing record, and the procedures for the conduct of the hearing; conduct the hearing within 20 school days and render a decision within 3 school days; remand the matter to the school district governing board, or conduct a hearing de novo if the county board of education determines that there is relevant and material evidence that should be considered; and notify the parties of the final and binding order. School districts are required to participate in the county board appeal process.

2. Commission on State Mandates Decisions

A. Pupil Suspensions

The Commission on State Mandates, in the Statement of Decision adopted at the December 19, 1996 hearing, determined that Education Code section 48911, subdivisions (b) and (e), limited to suspensions based upon (1) possession of a firearm (10/11/93 to present), and (2) possession of a knife or explosive (10/11/93 to 12/31/93), impose a reimbursable state mandated new program or higher level of service upon school districts within the meaning of section 6, article XIII B of the California Constitution and section 17514 of the Government Code.

B. Pupil Expulsions

The commission on State mandates, in the Statement of decision adopted at the May 26, 1997, hearing, found that certain provisions of Education Code sections 48915, subdivisions (a), (b), 48915.1, 48915.2, 48916, and 48918, subdivisions (b), (i), and (j), impose a reimbursable state mandated new program or higher level of service upon school districts within the meaning of section 6, article XIII B of the California Constitution and section 17514 of the Government Code.

The Commission further determined that certain of the foregoing sections imposed a new program or higher level of service only with respect to expulsion procedures instituted for certain specified offenses.

C. Expulsion Appeals

The Commission on State Mandates, in the Statement of Decision adopted at the March 27, 1997

hearing, found that certain provisions of Education Code sections 48919, 48921 through 48924, and limited to those expulsions based upon section 48915(b) as amended by Chapters 1255 and 1256, Statutes of 1993, impose a reimbursable state mandated new program or higher level of service upon school districts within the meaning of section 6, article XIII B of the California Constitution and section 17514 of the Government Code.

3. Eligible Claimants

Any school district (K-12) or county board of education that incurs increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

4. Appropriations

These claiming instructions are issued following the adoption of the program's parameters and guidelines by the Commission on State Mandates. Funding for payment of initial claims covering fiscal years 1993-94, 1994-95, 1995-96, 1996-97, and 1997-98, may be made available in a future appropriation act subject to the approval of the Legislature and the Governor.

To determine if this program is funded in subsequent fiscal years, refer to the schedule, "Appropriation for State Mandated Cost Programs," in the *"Annual Claiming Instructions for State Mandated Costs"* issued in September of each year to county superintendents of schools and superintendents of schools.

5. Types of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement and/or an estimated claim. A reimbursement claim details the costs actually incurred for a prior fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year.

B. Minimum Claim

Government Code § 17564(a) provides that no claim shall be filed pursuant to Government Code § 17561 unless such a claim exceeds $200 per program per fiscal year. However, any county superintendent of schools, as fiscal agent for the school district, may submit a combined claim in excess of $200 on behalf of districts within the county even if the individual district's claim does not exceed $200. A combined claim must show the individual costs for each district. Once a combined claim is filed, all subsequent years relating to the same mandate must be filed in a combined form. The county receives the reimbursement payment and is responsible for disbursing funds to each participating district. A district may withdraw from the combined claim form by providing a written notice to the county superintendent of schools and the State Controller's Office of its intent to file a separate claim at least 180 days prior to the deadline for filing the claim.

6. Filing Deadline

A. Initial Claims

Pursuant to Government Code section 17561, subdivision (d)(3), initial claims must be filed within 120 days from the issuance of claiming instructions. Accordingly:

(1) Reimbursement claims detailing the actual costs incurred for the 1993-94, 1994-95, 1995-96, 1996-97, and 1997-98 fiscal years must be filed with the State Controller's Office and postmarked by February 24, 1999. If the reimbursement claim is filed after the deadline of

February 24, 1999, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

(2) Estimated claims for costs to be incurred during the 1998-99 fiscal year must be filed with the State Controller's Office and postmarked by February 24, 1999. Timely filed estimated claims are paid before late claims. If a payment is received for the estimated claim, a 1998-99 reimbursement claim must be filed by January 15, 2000.

B. Annually Thereafter

Refer to the item, "Reimbursable State Mandated Cost Programs", contained in the cover letter for mandated cost programs issued annually in October, which identifies the fiscal years for which claims may be filed. If an "x" is shown for the program listed under "19__/19__ Reimbursement Claim", and/or "19__/19__ Estimated Claim", claims may be filed as follows:

(1) An estimated claim filed with the State Controller's Office must be postmarked by January 15 of the fiscal year in which costs are to be incurred. Timely filed estimated claims will be paid before late claims.

After having received payment for an estimated claim, the claimant must file a reimbursement claim by January 15 of the following fiscal year. If the district fails to file a reimbursement claim, monies received for the estimated claim must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. For information regarding appropriations for reimbursement claims, refer to the schedule, "Appropriation for State Mandated Cost Programs" in the previous fiscal year's annual claiming instructions.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by January 15 following the fiscal year in which costs were incurred. If the claim is filed after the deadline but by January 15 of the succeeding fiscal year, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

7. Reimbursable Activities

For each eligible school district and county board of education, the direct and indirect costs of labor, supplies, and services incurred for the following mandated components are reimbursable:

A. Adoption and Revision of Rules and Procedures

(1) County Boards of Education

(a) Adopting rules and procedures for expulsion appeal hearings and revising those rules and procedures to conform to amendments of the statutory hearing requirements.

(b) Printing and disseminating rules and procedures to each school district in the county.

(2) School Districts and County Boards of Education

(a) Adopting rules and procedures pertaining to pupil expulsions and revising those rules and procedures to conform to amendments of the statutory requirements.

(b) Adopting rules and regulations establishing the procedure for the filing and processing of requests for re-admission pursuant to Education Code section 48915.

(c) Printing and disseminating rules and procedures to each school site.

B. Suspension Conference and Report

If the suspension is for one of the following offenses and the offense occurred within the following dates:

Date of Offense	Offense
10/11/93 to 12/31/93	Possession of a firearm, knife of no reasonable use to the student, or explosive.
1/1/94 to Present	Possession of a firearm. [1]

Then the following activities are reimbursable:

(1) Attendance at Informal Conference

The attendance of the teacher, supervisor, or other school district employee who referred the pupil to the principal for suspension in the pre-suspension conference between the principal (or principal's designee) or superintendent and the pupil.

(2) Reporting the Cause to the District Office

Reporting the cause of the suspension to the school district's superintendent or governing board in accordance with the regulations of the school district's governing board. Such report may be oral or written.

C. Recommendation of Expulsion

The preparation of a report to the school district governing board concerning the principal's or superintendent's recommendation to expel a pupil for the following offenses:

(1) Causing serious physical injury to another person except in self defense;

(2) Possession of any firearm, knife, explosive, or other dangerous device of no reasonable use to the pupil at school or at a school activity off school grounds;

(3) Unlawful sale of any controlled substance listed in Chapter 2 (commencing with section 11053) of Division 10 of the Health and Safety Code, except for the first offense for the sale of not more than one avoirdupois ounce of marijuana, other than concentrated cannabis; or

(4) Robbery or extortion

D. Expulsion Hearing Procedural Requirements

If the expulsion hearing is for one of the following offenses:

(1) Causing serious physical injury to another person except in self defense;

(2) Possession of any firearm, knife, explosive, or other dangerous device of no reasonable use to the pupil at school or at a school activity off school grounds;

(3) Unlawful sale of any controlled substance listed in Chapter 2 (commencing with section 11053) of Division 10 of the Health and Safety Code, except for the first offense for the sale of not more than one avoirdupois ounce of marijuana, other than concentrated cannabis; or

(4) Robbery or extortion.

Then the following activities are reimbursable:.

I. Including in the notice of hearing to the pupil;

(a) A copy of the disciplinary rules of the district that relate to the alleged violation;

[1] Chapter 972/95 relettered § 48915(b) as § 48915(c) and added activities for which suspensions are required.

(b) A notice of the parent's, guardian's, or pupil's obligation, pursuant to Education Code Section 48915.1, subdivision (b), to notify a new school district, upon enrollment, of the pupil's expulsion; and

(c) Notice of the opportunity for the pupil or the pupil's parent or guardian to inspect and obtain copies of all documents to be used at the hearing.

II. Allowing a pupil or pupil's parent or guardian to inspect and obtain copies of documents to be used at the expulsion hearing, as follows:

(a) If the requesting party is a pupil less than 18 years of age or the parent or guardian of a pupil who is 18 years of age or older, all documents; or

(b) If the requesting party is the parent or guardian of a pupil under the age of 18, only those documents which are not "education records" as defined in 20 U.S.C. Section 1232g(a)(4).

E. Post-Expulsion Procedures

If the expulsion hearing is for one of the following offenses and the offense occurred within the following dates:

Date of Offense	Offense
10/11/93 to 12/31/93	Possession of a firearm, knife of no reasonable use to the student, or explosive.
1/1/94 to Present	Possession of a firearm. [1]

Then the following activities are reimbursable:

(1) Sending written notice to the pupil or the pupil's parent or guardian of: (a) Any decision by the governing board to expel or suspend the enforcement of an expulsion order during a period of probation; (b) the right to appeal the expulsion to the county board of education, and (c) the obligation of the pupil, parent, or guardian under Education Code section 48915.1 to notify a new school district, upon enrollment, of the pupil's expulsion. Costs of postage for mailing the notice is reimbursable under this activity.

(2) Maintaining a record of the expulsion, including the cause of the expulsion;

(3) Recording the expulsion order and the cause of the expulsion in the pupil's interim mandatory record; and

(4) Forwarding the student's mandatory interim record to any school in which the pupil subsequently enrolls upon the request of such school.

F. Re-admission Procedures

If the governing board expelled a pupil for one of the following offenses and the offense occurred within the following dates:

Date of Offense	Offense
10/11/93 to 12/31/93	Possession of a firearm, knife of no reasonable use to the student, or explosive.
1/1/94 to Present	Possession of a firearm. [1]

Then the following activities are reimbursable:

(1) Setting a date when the pupil may apply for re-admission to a district school; and

(2) Providing a description of the procedure for re-admission to the pupil and the pupil's parent or guardian.

G. Application by Expelled Pupil to Attend a New District

If a pupil ("applicant") seeking application to a school district (the "receiving school district") has been expelled by another school district for one of the following offenses as specified below, and the receiving school district does not have a voluntary interdistrict transfer agreement with the expelling district.

Date of Offense	Offense
7/1/93 to 12/31/93	(a) Causing serious physical injury to another person except in self defense;
	(b) Possession of any firearm, knife, explosive, or other dangerous device of no reasonable use to the pupil at school or at a school activity off school grounds;
	(c) Unlawful sale of any controlled substance listed in Chapter 2 (commencing with section 1053) of Division 10 of Health and Safety Code, except for the first offense for the sale of not more than one avoirdupois ounce of marijuana, other than concentrated cannabis; or
	(d) Robbery or extortion
1/1/94 to Present	For any offense.

Then the following activities associated with the receiving district's hearing are reimbursable, as specified below:

(1) Including in the notice of hearing to the applicant: (a) A copy of the hearing procedure rules of the receiving district; and (b) notice of the opportunity for the applicant or the applicant's parent or guardian to inspect and obtain copies of all documents to be used at the hearing.

(2) Allowing an applicant or applicant's parent or guardian to inspect and obtain copies of documents to be used at the admission hearing, as follows:

(a) If the requesting party is an applicant less than 18 years of age or the parent or guardian of an applicant who is 18 years of age or older, all documents; or

(b) If the requesting party is the parent or guardian of an applicant under the age of 18, only those documents that are not "education records" as defined in 20 U.S.C. Section 1232g(a)(4).

(3) Determination by the governing board whether a pupil expelled by another school district would pose a danger to the pupils and employees of the receiving district and whether to admit, deny admission, or conditionally admit the pupil during or after the period of expulsion.

(4) Maintaining a record of each admission denial, including the cause of the denial.

(5) Notifying the applicant and the applicant's parent or guardian of the governing board's determination of whether the applicant poses a potential danger to the pupils or employees of the receiving district and whether to admit, deny admission, or conditionally admit the applicant during or after the period of expulsion.

H. Responding to Requests for Recommendations

If the governing board expelled a pupil for one of the following offenses and the offense occurred within the following dates:

Date of Offense	Offense
10/11/93 to 12/31/93	Possession of a firearm, knife of no reasonable use to the student, or explosive.
1/1/94 to Present	Possession of a firearm. [1]

and the expelled student applies for admission to another school district (the "receiving district") then, unless the expelling district entered into a voluntary interdistrict transfer agreement with the receiving district, the activities of the expelling district in responding to the receiving district's request for a recommendation regarding the admission of the applicant are reimbursable.

I. Expulsion Appeals Hearings

(1) County Boards of Education (applicable to all student expulsion appeals)

(a) Providing Notice to the Parties

1. Notifying the pupil and the pupil's parent(s) or guardian(s) of the procedures for the appeal.

2. Notifying the school district and pupil in writing of the final order of the county board of education, either by personal service or certified mail.

(b) Review of Hearing Record

Reviewing the filed appeal, the transcript, and record of the hearing conducted by the school district governing board.

(c) Conducting Hearings

Conducting the initial appeal hearing and rendering a decision. Reimbursement for this component is limited to appeals for which the county board of education decides to grant a hearing de novo.

(d) Preserving Records

Preserving the record of appeal.

(2) School Districts

If the governing board expelled a pupil for one of the following offenses and the offense occurred within the following dates:

Date of Offense	Offense
10/11/93 to 12/31/93	Possession of a firearm, knife of no reasonable use to the student, or explosive.
1/1/94 to Present	Possession of a firearm. [1]

Then the following activities are reimbursable:

(1) Providing Copies of Documents

(a) Providing copies of supporting documents and records from the district's expulsion hearing (other than the transcript) to a pupil who is less than 18 years of age.

(b) Providing copies of supporting documents and records from the district's expulsion hearing (other than the transcript) to a pupil who is 18 years of age or older, or to the parent or guardian of a pupil who is less than 18 years of age, if the documents or records are not "education records" as defined in 20 U.S.C. section 1232g(a)(4).[1]

(2) Participation in Hearings

Participation by a school district in the county board of education's hearing on appeal if the county board of education grants a hearing de novo.

(3) Remand Hearing

If the county board of education remanded the expulsion to the school district's governing board following an appeal, sending notice of the hearing, conducting a hearing on demand, and rendering a decision in the remand hearing.

(4) Expunging Records

Expunging the school district's and pupil's records concerning the expulsion, when ordered by the county board of education.

J. Training

Training school district personnel about the mandated suspension, expulsion, and expulsion appeal activities. This reimbursable component includes the labor time of administrators and other school district personnel involved with preparation of training sessions and the labor time of other school district personnel who conduct or attend training sessions. **Labor time for teachers is not reimbursable**. The cost of materials and supplies used or distributed in training sessions is reimbursable under this component.

8. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate, shall be identified and deducted so only net local costs are claimed.

9. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms PSEA-1 and PSEA-2 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary. In such instances, new replacement forms will be mailed to claimants.

A. Form PSEA-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form PSEA-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits. In lieu of actual hours, the average number of hours devoted to each reimbursable activity can be claimed if supported by a documented time study. At present no instructions are available for performing a time study. Therefore, it is suggested that claims be based on actual costs.

Reimbursement for personal services include compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure. If a documented time study is the basis for claimed time spent, attach the time records with the claim. The State Controller's Office will review the documented time study for precision and reliability.

(2) Materials and Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of contractor(s) who performed the service(s), including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor, and give the number of actual hours spent on the activities, if applicable. Show the actual dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the expenditure.

(4) Travel Expenses

Travel expenses for mileage, per diem, lodging and other employee entitlements are reimbursable in accordance with the rules of the local jurisdiction. Provide the name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination points and costs.

Source documents may include, but are not limited to, employee travel expense claims, receipts, and other documents evidencing the travel expenses.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial claim at the time the claim was filed,

supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

B. Form PSEA-1, Claim Summary

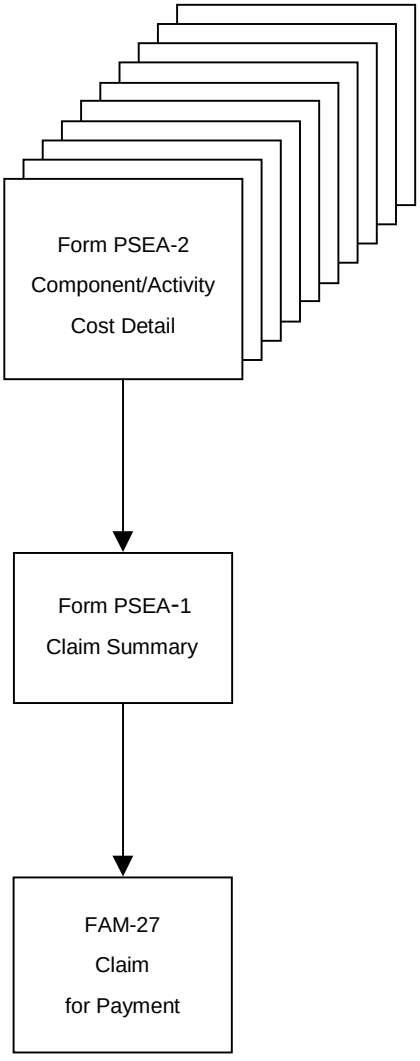
This form is used to summarize direct costs by claim component and compute allowable indirect costs for the mandate.

School districts and local boards of education may compute the amount of indirect costs utilizing the State Department of Education's Annual Program Cost Data Report J-380 or J-580 rate, as applicable. The cost data on this form is carried forward to form FAM-27.

C. Form FAM-27, Claim for Payment

Form FAM-27 contains a certification that must be signed by an authorized officer of the district. All applicable information from form PSEA-1 must be carried forward to this form for the State Controller's Office to process the claim for payment.

Illustration of Claim Form



Form PSEA-2 Component Activity Cost Detail
Complete a separate form PSEA-2 for each cost component in which expenses are claimed.

A. Adoption and Revision of Rules and Procedures
   1. County Boards of Education
   2. School Districts and County Boards of Education

B. Suspension Conference and Report
   1. Attendance at Informal Conference
   2. Reporting the Cause to the District Office

C. Recommendation of Expulsion
   1. Causing serious physical injury
   2. Possession of firearm, knife, explosive, or other device
   3. Unlawful sale of controlled substance
   4. Robbery or extortion

D. Expulsion Hearing procedural Requirements
   1. Inclusions in the Pupil's Notice of Hearing
   2. Inspecting and Obtaining Copies of Documents

E. Post Expulsion Procedures
   1. Sending Written Notice
   2. Maintaining Records
   3. Recording the order and cause of expulsion

F. Readmission Procedures
   1. Setting a Date for Readmission
   2. Providing Procedures for Readmission
   3. Application by Expelled Pupil to Attend New District

G. Application by Expelled Pupil to Attend New District
   1. Inclusions in the Pupil's Notice of Hearing
   2. Inspecting and Obtaining Copies of Documents
   3. Determination by the Governing Board
   4. Maintaining Records of Admission and Cause of Denials
   5. Notification of the Governing Board's Determination

H. Responding to Requests for Recommendations
   1. The Expelling District Response

I. Expulsion Appeals Hearing
   1. County Boards of Education
   2. School Districts

J. Training

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PUPIL SUSPENSION, EXPULSION, AND EXPULSION APPEALS

For State Controller Use Only

(19) Program Number 00176
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) PSEA-1, (03)(a)	
(23) PSEA-1, (03)(b)	
(24) PSEA-1, (03)(c)	
(25) PSEA-1, (04)(1)(e)	
(26) PSEA-1, (04)(2)(e)	
(27) PSEA-1, (04)(3)(e)	
(28) PSEA-1, (04)(4)(e)	
(29) PSEA-1, (04)(5)(e)	
(30) PSEA-1, (04)(6)(e)	
(31) PSEA-1, (04)(7)(e)	
(32) PSEA-1, (04)(8)(e)	
(33) PSEA-1, (04)(9)(e)	
(34) PSEA-1, (04)(10)(e)	
(35) PSEA-1, (06)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1253, Statutes of 1975, and Chapter 965, Statutes of 1977, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1253, Statutes of 1975, and Chapter 965, Statutes of 1977.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1253, Statutes of 1975, and Chapter 965, Statutes of 1977, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PUPIL SUSPENSION, EXPULSION, AND EXPULSION APPEALS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PSEA-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PSEA-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (35) for the reimbursement claim [e.g. PSEA-1, (03)(a), means the information is located on form PSEA-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS **PUPIL SUSPENSION, EXPULSIONS, AND EXPULSION APPEALS** **CLAIM SUMMARY**	**FORM PSEA-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

Claim Statistics

(03) (a) Number of students suspended in the fiscal year of claim	
(b) Number of students expelled in the fiscal year of claim	
(c) Number of expulsion appeals in the fiscal year of claim	

Direct Costs	**Object Accounts**				
(04) Reimbursable Components	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Travel	(d) Contract Services	(e) Total
1. Adoption and Revision of Rules and Procedures					
2. Suspension Conference and Report					
3. Recommendation of Expulsion					
4. Expulsion Hearing Procedural Requirements					
5. Post Expulsion Procedures					
6. Readmission Procedures					
7. Application by Expelled Pupil to Attend New District					
8. Responding to Requests for Recommendations					
9. Expulsion Appeals Hearing					
10. Training					
(05) Total Direct Costs					

Indirect Costs

(06) Indirect Cost Rate	[From J-380 or J-580]	%
(07) Total Indirect Costs	[Line (06) x line (05)(e)]	
(08) Total Direct and Indirect Costs	[Line (05)(e) + line (07)]	

Cost Reduction

(09) Less: Offsetting Savings, if applicable		
(10) Less: Other Reimbursements, if applicable		
(11) Total Claimed Amount	[Line (08) – {line (09) + line (10)}]	

PUPIL SUSPENSION, EXPULSIONS, AND EXPULSION APPEALS CLAIM SUMMARY Instructions	**FORM PSEA-1**

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form PSEA-1 must be filed for a reimbursement claim. Do not complete form PSEA-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form PSEA-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03)

Date of Offense	Offense
10/11/93 to 12/31/93	Possession of a firearm, knife of no reasonable use to the student, or explosive.
1/1/94 to Present	Possession of a firearm.

(a) Enter the number of suspensions for the number of offenses that occurred during the above time period.

(b) Enter the number of expulsions for the number of offenses that occurred during the above time period.

(c) Enter the number of expulsion appeals for the number of offenses that occurred during the above time period.

(04) Reimbursable Components. For each reimbursable component, enter the total from form PSEA-2, line (05), columns (d), (e), (f), and (g) to form PSEA-1, block (04), columns (a), (b), (c), and (d) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (e).

(06) Indirect Cost Rate. Enter the indirect cost rate from the Department of Education form J-380 or J-580, as applicable for the fiscal year of costs.

(07) Total Indirect Costs. Enter the result of multiplying the Indirect Cost Rate, line (06), by the Total Direct Costs, line (05)(e).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(e), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (13) for the Reimbursement Claim.

MANDATED COSTS
PUPIL SUSPENSION, EXPULSION, AND EXPULSION APPEALS
COMPONENT/ACTIVITY COST DETAIL

FORM PSEA-2

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Check only **one** box per form to identify the component being claimed.

- ☐ Adoption and Revision of Rules and Procedures
- ☐ Readmission Procedures
- ☐ Suspension Conference and Report
- ☐ Application by Expelled Pupil to Attend New District
- ☐ Recommendation of Expulsion
- ☐ Responding to Requests for Recommendations
- ☐ Expulsion Hearing Procedural Requirements
- ☐ Expulsion Appeals Hearing
- ☐ Post Expulsion Procedures
- ☐ Training

(04) Description of Expenses: Complete columns (a) through (g).

			Object Accounts			
(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries and Benefits	(e) Materials and Supplies	(f) Travel	(g) Contract Services
(05) Total ☐ Subtotal ☐ Page:____of____						

PUPIL SUSPENSION, EXPULSION, AND EXPULSION APPEALS COMPONENT/ACTIVITY COST DETAIL Instructions	**FORM PSEA-2**

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form PSEA-2 shall be prepared for each applicable component.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services and travel expenses. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial payment at the time the claim was filed, supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	**Columns**							**Submit these supporting documents with the claim**
	(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	**(g)**	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title Activities	Benefit Rate			Benefits = Benefit Rate x Salaries			
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used			Cost = Unit Cost x Quantity Used		
Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode				Rate x Days or Miles Total Travel Cost	
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service				Itemized Cost of Services Performed	Invoice

(05) Total line (04), columns (d), (e), (f), and (g) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Enter totals from line (05), columns (d), (e), (f), and (g) to form PSEA-1, block (04), columns (a), (b), (c), and (d) in the appropriate row.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PUPIL HEALTH SCREENINGS

For State Controller Use Only

(19) Program Number 00139
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) PHS-1, (03)(a)	
(23) PHS-1, (03)(b)	
(24) PHS-1, (03)(c)	
(25) PHS-1, (03)(d)	
(26) PHS-1, (03)(e)	
(27) PHS-1, (04)(1)(d)	
(28) PHS-1, (04)(2)(d)	
(29) PHS-1, (04)(3)(d)	
(30) PHS-1, (04)(4)(d)	
(31) PHS-1, (06)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapters 1208/76, 373/91, and 759/92, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapters 1208/76, 373/91, and 759/92.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapters 1208/76, 373/91, and 759/92, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PUPIL HEALTH SCREENINGS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PHS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PHS-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (25) for the reimbursement claim [e.g. PHS-1, (03), means the information is located on form PHS-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PUPIL CLASSROOM SUSPENSION: COUNSELING

For State Controller Use Only

(19) Program Number 00151
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	PCS-1, (03)(a)	
(23)	PCS-1, (03)(b)	
(24)	PCS-1, (03)(c)	
(25)	PCS-1, (03)(d)	
(26)	PCS-1, (04)(1)(d)	
(27)	PCS-1, (06)	
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 967, Statutes of 1977 and Chapter 498, Statutes of 1983, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 967, Statutes of 1977 and Chapter 498, Statutes of 1983.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 967, Statutes of 1977 and Chapter 498, Statutes of 1983, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PUPIL CLASSROOM SUSPENSION: COUNSELING **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03), Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04), Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05), Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PCS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09), Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10), Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11), Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PCS-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17), Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18), Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (25) for the reimbursement claim [e.g. PCS-1, (03)(a), means the information is located on form PCS-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
IMMUNIZATION RECORDS

For State Controller Use Only

(19) Program Number 00032
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) IR-1, (04)(b)	
(23) IR-1, (04)(c)	
(24)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1176, Statutes of 1977, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1176, Statutes of 1977.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1176, Statutes of 1977, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

IMMUNIZATION RECORDS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form IR-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form IR-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (23) for the reimbursement claim [e.g. IR-1, (04)(b), means the information is located on form IR-1, line (04)(b)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS IMMUNIZATION RECORDS CLAIM SUMMARY	**FORM IR-1**

(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19___/20___

Claim Statistics

(03) Number of new entrants for each school in the district			
(a) Name of School	(b) Kindergarten Entrants	(c) Out-of-State Transfers	(d) Total
(04) Total New Entrants			
(05) New Entrant Reimbursement Rate: $4.84 for 1999-00 actual and $4.97 for 2000-01 estimated			
(06) Total Indirect Costs [Line (04)(d) x line (05)] unit cost rate as appropriate			

Cost Reduction

(07) Less: Offsetting Savings, if applicable	
(08) Less: Other Reimbursements, if applicable	
(09) Total Claimed Amount [Line (06) – {line (07) + line (08)}]	

IMMUNIZATION RECORDS CLAIM SUMMARY Instructions	FORM IR-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form IR-1 must filed for a reimbursement claim. Do not complete form IR-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form IR-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Number of new entrants for each school in the district. List in column (a) each school in the district, in column (b) enter the number of kindergarten entrants, and in column (c) enter the number of out-of-state transfers.

(04) Total New Entrants. Add columns (b) and (c) and enter the total in column (d).

(05) New Entrant Reimbursement Rate. Enter the specified unit rate for the fiscal year of claim.

(06) Total Costs. Enter the product of multiplying Total New Entrants, line (04)(d), times the appropriate New Entrant Reimbursement Rate, line (05).

(07) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(08) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source (i.e., service fees collected, federal funds, other state funds etc.,) which reimbursed any portion of the mandated program. Submit a detailed schedule of the reimbursement sources and amounts.

(09) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (06), and Other Reimbursements, line (07), from Total Costs, line (05). Enter the remainder of this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
ABSENTEE BALLOTS

For State Controller Use Only

(19) Program Number 00170
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) AB-131, (03)	
(23) AB-13, (06)	
(24) AB-1.2, (03)(a)	
(25) AB-1.2, (03)(b)	
(26) AB-1.2, (03)(c)	
(27) AB-1.2, (03)(d)	
(28) AB- 1.2, (05)	
(29) AB- 1.3, (03)(a)	
(30) AB- 1.3, (03)(b)	
(31) AB- 1.3, (03)(c)	
(32) AB- 1.3, (03)(d)	
(33) AB- 1.3, (04)(d)	
(34) AB-1.3, (05)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 77, Statutes of 1978, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 77, Statutes of 1978.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 77, Statutes of 1978, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

ABSENTEE BALLOTS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form AB-1.1, AB-1.2, or AB-1.3, as applicable, and enter the amount.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form AB-1.1, AB-1.2, or AB-1.3.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (34) for the reimbursement claim [e.g. AB-1.3, (03)(a), means the information is located on form AB-1.3, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PUPIL EXCLUSIONS

For State Controller Use Only

(19) Program Number 00165
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	PE-1, (03)	
(23)	PE-1, (04)(1)(d)	
(24)	PE-1, (04)(2)(d)	
(25)	PE-1, (04)(4)(d)	
(26)	PE-1, (06)	
(27)	PE-1, (08)	
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 668, Statutes of 1978, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 668, Statutes of 1978.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 668, Statutes of 1978, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PUPIL EXCLUSIONS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PE-1 and enter the amount from line (12).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PE-1, line (12).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (27) for the reimbursement claim [e.g. PE-1, (03), means the information is located on form PE-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PHYSICAL EXAMINATION FOR SCOLIOSIS

For State Controller Use Only

(19) Program Number 00058
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) PES-1, (03)(a)	
(23) PES-1, (03)(b)	
(24) PES-1, (03)(c)	
(25) PES-1, (04)	
(26) PES-1, (05)(1)(d)	
(27) PES-1, (05)(2)(d)	
(28) PES-1, (05)(3)(d)	
(29) PES-1, (05)(04)(d)	
(30) PES-1, (07)	
(31) PES-1, (09)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1347, Statutes of 1980, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1347, Statutes of 1980.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1347, Statutes of 1980, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PHYSICAL EXAMINATION FOR SCOLIOSIS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PES-1 and enter the amount from line (12). If more than one form PES-1 is completed due to multiple department involvement in this mandate, add line (12) of each form PES-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PES-1, line (12). If more than one form PES-1 is completed due to multiple department involvement in this mandate, add line (12) of each form PES-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (31) for the reimbursement claim [e.g. PES-1, (03)(a), means the information is located on form PES-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS PHYSICAL EXAMINATION FOR SCOLIOSIS CLAIM SUMMARY	FORM PES-1

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

Claim Statistics

(03) (a) Number of students screened	
(b) Number of students rescreened	
(c) Number of students referred to medical care	

Unit Cost Method

(04) Total Costs [Line (03)(a) x $5.80 per student for 1999-2000 F.Y.]	

Actual Cost Method

Direct Costs	**Object Accounts**			
(05) Reimbursable Components	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Contract Services	(d) Total
1. Parental Notification				
2. Examination of Students				
3. Rescreening and Referral				
(06) Total Direct Costs				

Indirect Costs

(07) Indirect Cost Rate [From J-380 or J-580]	%
(08) Total Indirect Costs [Line (06)(d) x line (07)]	
(09) Total Direct and Indirect Costs [Line (06)(d) + line (08)]	

Cost Reduction

(10) Less: Offsetting Savings, if applicable	
(11) Less: Other Reimbursements, if applicable	
(12) Total Claimed Amount [Line (04) or line (09) – {line (10) + line (11)}]	

PHYSICAL EXAMINATION FOR SCOLIOSIS CLAIM SUMMARY Instructions	FORM PES-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

From PES-1 must be filed for a reimbursement claim. Do not complete form PES-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form PES-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (a) Number of students screened. Enter the number of students, seventh grade females and eighth grade males.

(b) Number of students rescreened. Enter the number of students who are questionable after the first screening and are screened again at a later date by someone other than the original screener. Only claimants who select the Actual Cost Method of reimbursement must provide data on the number of students rescreened.

(c) Number of students referred to medical care. Enter the number of students who have positive indication of scoliosis and are referred to medical care. Only the claimants who select the Actual Cost Method of reimbursement must provide data on the number of students referred to medical care.

(04) Total Costs. If you are using the Unit Cost Method, multiply line (03)(a) by $5.80, the reimbursable unit cost per student for the 1999-00 fiscal year. Do not complete line (05) through (09). Proceed directly to line (10) and complete through line (12).

(05) Reimbursable Components. If you are using the Actual Cost Method, enter the cost related to each reimbursable component from form PES-2, line (05), columns (d), (e), and (f). Total each row.

Do not complete line (04) if you are using the Actual Cost Method of reimbursement.

(06) Total Direct Costs. Total block (05), columns (a), (b), (c), and (d).

(07) Indirect Cost Rate. Enter the indirect cost rate from the Department of Education form J-380 or J-580, as applicable, for the fiscal year of claim.

(08) Indirect Costs. Enter the result of multiplying Total Direct Costs, line (06)(d), by the Indirect Cost Rate, line (07).

(09) Total Costs. Enter the sum of line (06)(d) and line (08).

(10) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(11) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source (i.e., service fees collected, federal funds, other state funds, etc.,) which reimbursed any portion of the mandated cost program. Submit a detailed schedule of the reimbursement sources and amounts.

(12) Total Claimed Amount. If the Unit Cost Method is used, subtract the sum of Offsetting Savings, line (10), and Other Reimbursements, line (11), from Total Costs, line (04). Enter the remainder of this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
GRADUATION REQUIREMENTS

For State Controller Use Only

(19) Program Number 00026
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) GR -1, (03)	
(23) GR -1, (04)(1)(e)	
(24) GR -1, (04)(2)(e)	
(25) GR -1, (04)(3)(e)	
(26) GR -1, (08)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 498, Statutes of 1983, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 498, Statutes of 1983.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 498, Statutes of 1983, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

GRADUATION REQUIREMENTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form GR-1 and enter the amount from line (13).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form GR-1, line (13).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (26) for the reimbursement claim [e.g. GR-1, (03), means the information is located on form GR-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS **GRADUATION REQUIREMENTS** **COMPONENT/ACTIVITY COST DETAIL**	**FORM** **GR-2**

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Check only **one** box per form to identify the component being claimed.

☐ Acquisition Cost ☐ Remodeling Cost

☐ Staffing and Supplies

(04) Description of Expenses: Complete columns (a) through (g).

(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	**Object Accounts** (d) Salaries and Benefits	(e) Materials and Supplies	(f) Contract Services	(g) Capital Outlays
(05) Total ☐ Subtotal ☐ Page:____of____						

GRADUATION REQUIREMENTS COMPONENT/ACTIVITY COST DETAIL Instructions	**FORM GR-2**

(01) Enter the name of the claimant.

(02) Enter the fiscal year in which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form GR-2 shall be prepared for each applicable component.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services, and capital outlays needed to acquire space and equipment. Contract Services are reimbursable to the extent that activities performed require special skills or knowledge that are not readily available from the claimant's' staff. The maximum reimbursable fee for contract services is $104.58 for the 1999-00 fiscal year. If a piece of equipment acquired for the Graduation Requirement program is also utilized for other programs, only a prorated cost of the equipment is reimbursable. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial payment at the time the claim was filed, supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	**Columns**							**Submit these supporting documents with the claim**
	(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	**(g)**	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked				
Benefits	Title Activities	Benefit Rate		Benefits = Benefit Rate x Salaries				
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used		Cost = Unit Cost x Quantity Used			
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed		Invoice
Capital Outlays	Description of Equipment Purchased Equipment ID	Unit Cost	Quantity Used				Itemized Cost of Equipment Purchased	Invoice

(05) Total line (04), columns (d), (e), (f), (g), and (h) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component costs, number each page. Enter totals from line (05), columns (d), (e), (f), (g), and (h) to form GR-1, block (04), columns (a), (b), (c), (d) and (e) in the appropriate row.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
NOTIFICATION OF TRUANCY

For State Controller Use Only

(19) Program Number 00048
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) NOT-1, (03)	
(23)	
(24)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 498, Statutes of 1983, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 498, Statutes of 1983.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 498, Statutes of 1983, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

NOTIFICATION OF TRUANCY Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form NOT-1 and enter the amount from line (08).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form NOT-1, line (08).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column for line (22) for the reimbursement claim [e.g. NOT-1, (03), means the information is located on form NOT-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS NOTIFICATION OF TRUANCY CLAIM SUMMARY	**FORM NOT-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

Claim Statistics	
(03) Number of truant notifications	
Cost	
(04) Unit Cost per an initial truancy notification ($12.23 for the 1999-00 fiscal year)	
(05) Total Costs [Line (03) x line (04)]	
Cost Reduction	
(06) Less: Offsetting Savings, if applicable	
(07) Less: Other Reimbursements, if applicable	
(08) Total Claimed Amount [Line (05) – {line (06) + line (07)}]	

NOTIFICATION OF TRUANCY CLAIM SUMMARY Instructions	FORM NOT-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form NOT-1 must filed for a reimbursement claim. Do not complete form NOT-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form NOT-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Number of truant notifications. Enter the number of initial notifications sent upon the student's fourth unexcused absence to inform the parent or guardian of their child's absence from school without a valid excuse or is tardy in excess of thirty (30) minutes for more than three days in one school year.

(04) Unit cost rate for the 1999-00 fiscal year is $12.23 per initial notification. This cost rate will be updated yearly and listed in the annual updates to claiming instructions mailed to school districts in September.

(05) Total Costs. Multiply line (03) by the unit cost rate, line (04).

(06) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(07) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source (i.e., service fees collected, federal funds, other state funds etc.,) which reimbursed any portion of the mandated program. Submit a detailed schedule of the reimbursement sources and amounts.

(08) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (06), and Other Reimbursements, line (07), from Total Costs, line (05). Enter the remainder of this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
HEALTH FEE ELIMINATION

For State Controller Use Only

(19) Program Number 00029
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	HFE-1.0, (04)(b)	
(23)		
(24)		
(25)		
(26)		
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1, Statutes of 1984 and Chapter 1118/87, Statutes of 1987; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1, Statutes of 1984 and Chapter 1118, Statutes of 1987.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1, Statutes of 1984 and Chapter 1118, Statutes of 1987, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

HEALTH FEE ELIMINATION Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form HFE-1.0 and enter the amount from line (04)(b).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form HFE-1.0, line (04)(b).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. HFE-1.0, (04)(b), means the information is located on form HFE-1.0, line (04)(b)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
REMOVAL OF CHEMICALS

For State Controller Use Only

(19) Program Number 00057
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) RC-1, (03)			
(23) RC-1, (0)(1)(e)			
(24) RC-1, (06)			
(25) RC-1, (08)			
(26)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1107, Statutes of 1984, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1107, Statutes of 1984.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1107, Statutes of 1984, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

REMOVAL OF CHEMICALS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form RC-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form RC-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. RC-1, (03), means the information is located on form RC-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Juvenile Court Notices II

1. Summary of Chapter 1423/84, 1019/94, 71/95

Welfare and Institutions Code Section 827, as amended by Chapter 1423, Statutes of 1984, requires school district superintendents to distribute to relevant schoolsite personnel written notices provided to them by the juvenile court system regarding pupils enrolled in their district who have been convicted of certain felonies and to destroy these notices after 12 months.

Chapter 1019, Statutes of 1994, amended Welfare and Institutions Code Section 827 to require record retention and information dissemination procedures in addition to the activities mandated by Chapter 1423, Statutes of 1984.

Chapter 71, Statutes of 1995, amended Welfare and Institutions Code Section 827 to eliminate the requirement that court records in the confidential student file be removed after 12 months.

On February 29, 1996, the Commission on State Mandates determined that Chapters 1423/84, 1019/94, and 71/95 resulted in state mandated costs that are reimbursable pursuant to Part 7 (commencing with Government Code Section 17500) of Division 4 of Title 2.

2. Eligible Claimants

With the exception of community colleges, any school district as defined in Government Code Section 17519 that incurs increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Appropriations

These claiming instructions are issued following the adoption of the program's parameters and guidelines by the Commission on State Mandates. To determine if funding is available for the current fiscal year, refer to the schedule "Appropriations for State Mandated Cost Programs" in the "Annual Claiming Instructions for State Mandated Costs" issued in October of each year to the county superintendent of schools and superintendents of schools.

4. Types of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement and/or an estimated claim. A reimbursement claim details the costs actually incurred for a prior fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year.

B. Minimum Claim

Section 17564(a) of the Government Code provides that no claim shall be filed pursuant to Section 17561 unless such a claim exceeds $200 per program per fiscal year. However, any county superintendent of schools, as fiscal agent for the school districts, may submit a combined claim in excess of $200 on behalf of one or more districts within the county even if the individual district's claim does not exceed $200. A combined claim must show the individual claim costs for each district. Once a combined claim is filed, all subsequent fiscal years relating to the same mandate must be filed in a combined form. The county superintendent receives the reimbursement payment and is responsible for disbursing funds to each participating school district. A school district may withdraw from the combined claim form by providing a written notice of its intent to file a separate claim to the county superintendent of schools and the State Controller's Office at least 180 days prior to the deadline for filing the claim.

5. Filing Deadline

A. Initial Claims

Pursuant to Government Code Section 17561, Subdivision (d)(3), initial and revised claims must be filed within 120 days from the issuance date of claiming instructions. Accordingly:

(1) Reimbursement claims detailing the actual costs incurred for the 1997-98, and 1998-99 fiscal years must be filed with the State Controller's Office and postmarked by April 4, 2000. If the reimbursement claim is filed after the deadline of April 4, 2000, the approved claim must be reduced by a penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

(2) Estimated claims for costs to be incurred during the 1999-00 fiscal year must be filed with the State Controller's Office and postmarked by April 4, 2000. Timely filed estimated claims are paid before late claims. If a payment is received for the estimated claim, a 1999-2000 reimbursement claim must be filed by January 15, 2001.

B. Annually Thereafter

Refer to the item, "Reimbursable State Mandated Cost Programs," contained in the cover letter for mandated cost programs issued annually in October that identifies the fiscal years for which claims may be filed. If an "x" is shown for the program listed under "19__/19__ Reimbursement Claim," and/or "19__/20__ Estimated Claim," claims may be filed as follows:

(1) An estimated claim filed with the State Controller's Office must be postmarked by January 15 of the fiscal year in which the costs will be incurred. Timely filed estimated claims will be paid before late claims.

After having received payment for an estimated claim, the claimant must file a reimbursement claim by January 15 of the following fiscal year. If the school district fails to file a reimbursement claim, monies received for the estimated claim must be returned to the State. If no estimated claim was filed, the school district may file a reimbursement claim detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. For information regarding appropriations for reimbursement claims refer to the "Appropriation for State Mandated Cost Programs" in the previous fiscal year's annual claiming instructions.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by January 15 following the fiscal year in which the costs will be incurred. If the claim is filed after the deadline but by January 15 of the succeeding fiscal year, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

6. Reimbursable Activities

For each eligible claimant, all direct and indirect costs of labor, materials and supplies, and contract services for the following activities only are eligible for reimbursement:

A. Superintendent's Distribution of the Notice

The superintendent shall receive and expeditiously transmit, upon return of the minor to school, the juvenile court notice either to the counselor having direct supervisorial or disciplinary responsibility over the minor at the school of attendance, or to the new school district of attendance.

B. Record Retention and Destruction

School personnel shall maintain any information received from the court in a separate confidential file at the school of attendance until the minor graduates from high school, is released from juvenile court jurisdiction, or reaches the age of eighteen, or shall transfer the confidential file to the minor's subsequent school of attendance for that school's retention, whichever occurs first. For fiscal year 1994-95, school personnel shall destroy any juvenile court information contained in the confidential file 12 months after the particular information is received or the pupil returns to school, whichever occurs last. Beginning July 6, 1995, this removal and destruction is no longer required.

C. Response to Destruction Inquiry

The principal of the school of attendance, or the principal's designee, shall respond in writing within 30 days, to written requests of the minor or his/her parent or guardian that the minor's school record be reviewed to ensure that the record has been destroyed.

D. Directory of Schools

The county superintendent shall provide the court with a listing of all schools within each school district within the county, and the name and mailing address of each district superintendent.

7. Reimbursable Method

A. Unit Cost Method

Pursuant to Government Code Section 17557, the Commission on State Mandates has adopted a uniform cost allowance for reimbursement in lieu of actual costs incurred beginning in the fiscal year 1997-98. The uniform cost allowance is an all inclusive rate that covers all costs, direct and indirect, incurred in compliance with this mandate for **Reimbursable Activities, 6. A** through **C**.

(1) The uniform cost allowance shall be $32.00 per notice beginning with fiscal year 1997-98 for **Reimbursable Activities A**. and **B**. Claims shall be reimbursed based upon the number of court notices received from the juvenile court system and distributed to school district personnel, multiplied by the uniform cost allowance.

(2) The uniform cost allowance shall be $22.75 per request beginning with fiscal year 1997-98 for components included in **Reimbursable Activity C.** Claims shall be reimbursed based upon the number of written requests received from parents or guardians to review the record to ensure the record has been destroyed, multiplied by the uniform cost allowance.

The uniform cost allowance shall be adjusted upward or downward as appropriate, each subsequent year by the Implicit Price Deflator referenced in Government Code Section 17523. The unit cost allowance for the 1998-99 fiscal year is $32.52 for **Reimbursable Activities A. and B.** and $23.12 for **Reimbursable Activity C.** Refer to form JCN-1 showing the current unit cost rate that should be used for the fiscal year of costs.

B. Actual Cost Method

Actual costs incurred for labor and materials and supplies for the county superintendent to provide the court with a listing of all schools within each school district, within the county, along with the name and mailing address of each district superintendent as prescribed by **Reimbursable Activity D**. No uniform cost allowance has been established for this component.

8. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate shall be identified and deducted so only the net local cost is claimed. COSM has identified as a specific offset any payments received under Chapter 1011, Statutes of 1984.

9. Claiming Forms and Instructions

The diagram, "Illustration of Claim Forms," provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms JCN-1 and JCN-2 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary.

A. Form JCN-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form JCN-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s) and/or show the classification of each employee(s) involved. Describe the mandated functions performed by each employee and specify the actual time spent, the productive hourly rate, and related fringe benefits. In lieu of actual hours, the average number of hours devoted to each reimbursable activity may be claimed if supported by a documented time study. At the present no instructions are available for performing a time study. Therefore, it is suggested that claims be based on actual costs.

Reimbursement of personnel services includes compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g. annual leave, sick leave) and the employer's contribution to social security, pension plans, insurance, and workers' compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities that the employee performs.

Source documents required to be maintained by the claimant may include, but are not limited to, employee time records that show the employee's actual time spent on this mandate.

(1) Materials and Supplies

Only expenditures that can be identified as a direct result of this mandate may be claimed. List the cost of materials consumed or expended specifically for the purpose of this mandate. The cost of materials and supplies that are not used exclusively for the mandate is limited to the pro rata portion used to comply with this mandate. Purchase shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents required to be maintained by the claimant may include, but are not limited to, invoices, receipts, purchase orders, and other documents evidencing the validity of the expenditures.

(2) Contract Services

Contract services approved by the school district's governing board are reimbursable. Give the name(s) of the contractor(s) who performed the services. Describe the activities performed by each named contractor, actual time spent on this mandate, inclusive dates when services were performed and itemize all costs for services performed. Attach consultant invoices with the claim.

Source documents required to be maintained by the claimant may include, but are not limited to, contracts, invoices, and other documents evidencing the validity of the expenditures.

For audit purposes all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. If no funds were appropriated for the initial claim at the time the claim was filed, supporting documents must be retained for two years from the date of the initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

B. Form JCN-1, Claim Summary

This form is used to compute costs for **6. Reimbursable Activities A, B, and C** using the Unit Cost Method and to summarize direct costs for **6. Reimbursable Activity D** using the Actual Cost Method.

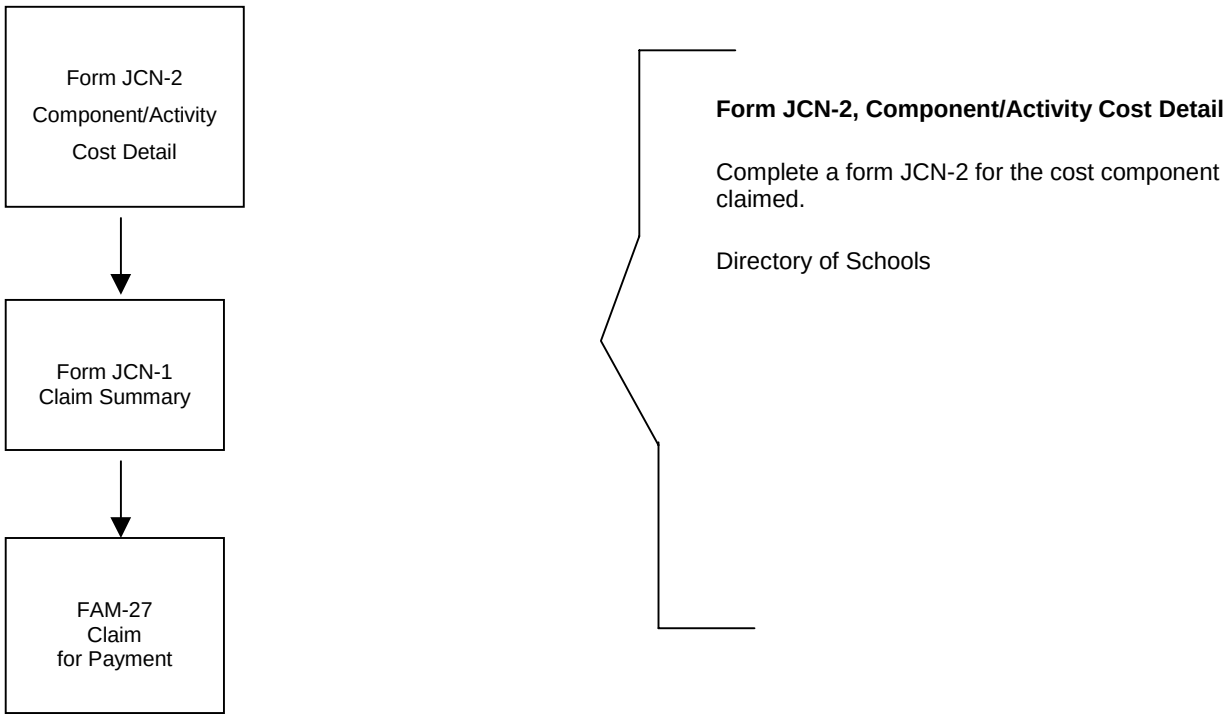
The direct costs summarized on this form for **6. Reimbursable Activity D**, are derived from form JCN-2. The total costs on this form are carried forward to form FAM-27. Claim statistics shall identify the work performed for costs claimed. The claimant must give (1) the average daily attendance for the fiscal year of claim and (2) the number of juvenile court notices received during the fiscal year of claim.

School districts and local boards of education may compute the amount of indirect costs utilizing the State Department of Education's Annual Program Cost Data Report J-380 or J-580 rate, as applicable. The cost data on this form is carried forward to form FAM-27.

C. Form FAM-27, Claim for Payment

This form contains a certification that must be signed by an authorized representative of the local agency. All applicable information from form JCN-1 must be carried forward to this form for the State Controller's Office to process the claim for payment.

Illustration of Forms



CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
JUVENILE COURT NOTICES II

For State Controller Use Only

(19) Program Number 00155
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	JCN-1, (03)(a)	
(23)	JCN-1, (03)(b)	
(24)	JCN-1, (03)(c)	
(25)	JCN-1, (06)	
(26)	JCN-1, (08)	
(27)	JCN-1, (09)	
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1423, Statutes of 1984, Chapter 1019, Statutes of 1994, and Chapter 71, Statutes of 1995; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by by Chapter 1423, Statutes of 1984, Chapter 1019, Statutes of 1994, and Chapter 71, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of by Chapter 1423, Statutes of 1984, Chapter 1019, Statutes of 1994, and Chapter 71, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

JUVENILE COURT NOTICES II Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form JCN-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form JCN-1, line (14).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. JCN-1, (03)(a), means the information is located on form JCN-1, line (03)(a). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS JUVENILE COURT NOTICES II CLAIM SUMMARY	FORM JCN-1

(01) Claimant	(02) Type of Claim Reimbursement ☐ Estimated ☐	Fiscal Year 19___/20___

Claim Statistics

(03) (a) Average daily attendance (ADA) for the fiscal year	
(b) Number of juvenile court notices received during the fiscal year	
(c) Number of written requests received for destruction inquiry during fiscal year of claim	

Unit Cost Method – Reimbursable Activities A, B, and C

(04) Cost of (03)(b)	[Line (03)(b) x unit cost per court notice]	
(05) Cost of (03)(c)	[Line (03)(c) x unit cost per inquiry received]	
(06) Total Costs	[Line (04) + line (05)]	

Actual Cost Method – Reimbursable Activity D

Direct Costs	**Object Accounts**			
(07) Reimbursable Components	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Contract Services	(d) Total
Directory of Schools				
(08) Total Direct Costs				

Indirect Costs

(09) Indirect Cost Rate	[From J-380 or J-580]	%
(10) Total Indirect Costs	[Line (09) x line (08)(d)]	
(11) Total Direct and Indirect Costs	[Line (06) + line (08)(d) + line (10)]	

Cost Reduction

(12) Less: Offsetting Savings, if applicable	
(13) Less: Other Reimbursements, if applicable	
(14) Total Claimed Amount [Line (11) – {line (12) + line (13)}]	

JUVENILE COURT NOTICES II CLAIM SUMMARY Instructions	FORM JCN-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form JCN-1 must be filed for a reimbursement claim. Do not complete form JCN-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form JCN-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (a) Average daily attendance (ADA) for the fiscal year of claim.

(b) Number of juvenile court notices received during the fiscal year.

(c) Number of written requests that were received during the fiscal year of claim regarding destruction inquiry.

(04) Enter the product of the number of juvenile court notices received, line (03)(b), times the unit cost allowance per court notice ($32.00 for 1997-98, $32.53 for 1998-99, and $33.80 for 1999-00).

(05) Enter the product of the number of written requests received from parents or guardians to review the records times the unit cost allowance per inquiry ($22.75 for 1997-98, $23.13 for 1998-99, and $24.03 for 1999-00).

(06) Enter the total costs by adding lines (04) and (05).

(07) Reimbursable Activities. For the reimbursable component, enter the totals from form JCN-2 line (05), columns (d), (e), and (f) to form JCN-1, block (07), columns (a), (b), and (c).

(08) Total Direct Costs. Total columns (a) through (c).

(09) Indirect Cost Rate. Enter the indirect cost rate from the Department of Education form J-380 or J-580, as applicable, for the fiscal year of the costs.

(10) Total Indirect Costs. Enter the result of multiplying the Total Direct Costs, line (08)(d) by the Indirect Cost Rate, line (09).

(11) Total Direct and Indirect Costs. Enter the sum of Total Costs, line (06), Total Direct Costs, line (08), and Total Indirect Costs, line (10).

(12) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(13) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(14) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (12), and Other Reimbursements, line (13), from Total Direct and Indirect Costs, line (11). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS JUVENILE COURT NOTICES II COMPONENT/ACTIVITY COST DETAIL	FORM JCN-2

(01) Claimant	(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Directory of Schools

(04) Description of Expenses: Complete columns (a) through (f).			Object Accounts		
(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries and Benefits	(e) Materials and Supplies	(f) Contract Services
(05) Total ☐ Subtotal ☐ Page:____of____					

JUVENILE COURT NOTICES II **COMPONENT/ACTIVITY COST DETAIL** **Instructions**	**FORM** **JCN-2**

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Components. Directory of Schools.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component, enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contracted services, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial payment at the time the claim was filed, supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	**Columns**						**Submit these supporting documents with the claim**
	(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	
Salaries	Employee Name	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked			
Benefits	Title Activities	Benefit Rate		Benefits = Benefit Rate x Salaries			
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used		Cost = Unit Cost x Quantity Used		
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service			Itemized Cost of Services Performed	Invoice

(05) Total line (04), columns (d), (e), and (f) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity, number each page. Enter totals from line (05), columns (d), (e), and (f) to form JCN-1, block (07), columns (a), (b), and (c) in the appropriate row.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SCHOOL CRIMES STATISTICS REPORTING AND VALIDATION

For State Controller Use Only

(19) Program Number 00109
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) SC-1, (03)	
(23) SC-1, (04)(1)(d)	
(24) SC-1, (04)(2)(d)	
(25) SC-1, (04)(3)(d)	
(26) SC-1, (04)(4)(d)	
(27) SC-1, (06)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1607, Statutes of 1984, Chapter 78, Statutes of 1988, and Chapter 1457, Statutes of 1988; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1607, Statutes of 1984, Chapter 78, Statutes of 1988, and Chapter 1457, Statutes of 1988.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1607, Statutes of 1984, Chapter 78, Statutes of 1988, and Chapter 1457, Statutes of 1988, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SCHOOL CRIMES STATISTICS REPORTING AND VALIDATION **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SC-1 and enter the amount from line (11). If more than one form SC-1 is completed due to multiple department involvement in this mandate add line (11) of each form SC-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SC-1, line (11). If more than one form SC-1 is completed due to multiple department involvement in this mandate add line (11) of each form SC-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. SC-1, (03), means the information is located on form SC-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT

Pursuant to Government Code Section 17561

EMERGENCY PROCEDURES: EARTHQUAKE AND DISASTERS

For State Controller Use Only

(19) Program Number 00075
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) EPED-1, (04)(1)(d)			
(23) EPED-1, (04)(2)(d)			
(24) EPED-1, (06)			
(25)			
(26)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1659, Statutes of 1984, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1659, Statutes of 1984.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1659, Statutes of 1984, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

EMERGENCY PROCEDURES: EARTHQUAKE AND DISASTERS **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form EPED-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form EPED-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. EPED-1, (04)(1)(d), means the information is located on form EPED-1, line (04)(1)(d)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SCHOOLSITE DISCIPLINE RULES

For State Controller Use Only

(19) Program Number 00146
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim	Reimbursement Claim Data	
			(22) SDR-1, (04)	
			(23)	
			(24)	
			(25)	
			(26)	
	(03) Estimated ☐	(09) Reimbursement ☐	(27)	
	(04) Combined ☐	(10) Combined ☐	(28)	
	(05) Amended ☐	(11) Amended ☐	(29)	
			(30)	
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___	(31)	
Total Claimed Amount	(07)	(13)	(32)	
Less: **10% Late Penalty, not to exceed $1,000**		(14)	(33)	
Less: **Estimated Claim Payment Received**		(15)	(34)	
Net Claimed Amount		(16)	(35)	
Due from State	(08)	(17)	(36)	
Due to State		(18)	(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 87, Statutes of 1986, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 87, Statutes of 1986.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 87, Statutes of 1986, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SCHOOLSITE DISCIPLINE RULES Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SDR-1 and enter the amount from line (07).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SDR-1, line (07).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. SDR-1, (04), means the information is located on form SDR-1, line (04)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS SCHOOLSITE DISCIPLINE RULES CLAIM SUMMARY	**FORM SDR-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

(03) Reimbursable Components

(a) School Types	(b) Number of Copies of Schoolsite Discipline Rules Distributed	(c) Unit Reimbursement	(d) (b) x (c) Total Costs
1. Elementary Schools			
2. Middle/Junior High Schools			
3. High Schools			
4. Other Schools			

(04) Total Costs	
(05) Less: Offsetting Savings, if applicable	
(06) Less: Other Reimbursements, if applicable	
(07) Total Claimed Amount [Line (04) - {line (05) + line (06)}]	

SCHOOLSITE DISCIPLINE RULES CLAIM SUMMARY Instructions	FORM SDR-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year for which costs were incurred or are to be incurred.

Form SDR-1 must be filed for a reimbursement claim. Do not complete form SDR-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form SDR-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) (b) Enter the number of copies of schoolsite discipline rules distributed to students of each school type. "Other Schools" include K-12, Continuation High, Alternative, Special Education, and Juvenile Hall/Court/Community Schools. In lieu of the number of copies of rules distributed to students, the actual district enrollment for the school type at the time of distribution or the district's annual average daily attendance (ADA) by school type can be used.

(c) Enter the unit reimbursement rates for the school type as follows:

Fiscal Years	Elementary Schools	Middle/Junior High	High Schools	Other Schools
1993-94	$0.2000	$0.2500	$0.3500	$0.3500
1994-95	0.2047	0.2558	0.3582	0.3582
1995-96	0.2109	0.2636	0.3691	0.3691
1996-97	0.2164	0.2704	0.3786	0.3786
1997-98	0.2197	0.2746	0.3844	0.3844
1998-99	0.2234	0.2792	0.3909	0.3909
1999-00	0.2332	0.2916	0.4082	0.4082

(d) Enter the total of Multiplying columns (b) times (c).

(04) Total Costs. Enter the total for column (d).

(05) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(06) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(07) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (05), and Other Reimbursements, line (06), from Total Costs, line (04). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
INTERDISTRICT ATTENDANCE PERMITS

For State Controller Use Only

(19) Program Number 00148
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) IAP-1, (03)(a)	
(23) IAP-1, (03)(b)	
(24) IAP-1, (03)(c)	
(25) IAP-1, (03)(d)	
(26) IAP-1, (03)(e)	
(27) IAP-1, (03)(f)	
(28) IAP-1, (03)(g)	
(29) IAP-1, (04)(1)(d)	
(30) IAP-1, (04)(2)(d)	
(31) IAP-1, (04)(3)(d)	
(32) IAP-1, (04)(4)(d)	
(33) IAP-1, (04)(5)(d)	
(34) IAP-1, (04)(6)(d)	
(35) IAP-1, (04)(7)(d)	
(36) IAP-A, (06)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 172, Statutes of 1986, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 172, Statutes of 1986.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 172, Statutes of 1986, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

INTERDISTRICT ATTENDANCE PERMITS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form IAP-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form IAP-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. IAP-1, (03)(a), means the information is located on form IAP-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
INTERDISTRICT TRANSFER REQUESTS: PARENT'S EMPLOYMENT

For State Controller Use Only

(19) Program Number 00149
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	ITR-1, (03)(a)	
(23)	ITR-1, (03)(b)	
(24)	ITR-1, (03)(c)	
(25)	ITR-1, (04)(1)(d)	
(26)	ITR-1, (04)(2)(d)	
(27)	ITR-1, (04)(3)(d)	
(28)	ITR-1, (04)(4)(d)	
(29)	ITR-1, (04)(5)(d)	
(30)	ITR-1, (06)	
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 172, Statutes of 1986, Chapter 10, Statutes of 1990, and Chapter 507, Statutes of 1992; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 172, Statutes of 1986, Chapter 10, Statutes of 1990, and Chapter 507, Statutes of 1992.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 172, Statutes of 1986, Chapter 10, Statutes of 1990, and Chapter 507, Statutes of 1992, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

INTERDISTRICT TRANSFER REQUESTS: PARENT'S EMPLOYMENT **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form ITR-1 and enter the amount from line (11). If more than one form ITR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form ITR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form ITR-1, line (11). If more than one form ITR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form ITR-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. ITR-1, (03)(a), means the information is located on form ITR-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
OPEN MEETINGS ACT

For State Controller Use Only

(19) Program Number 00092
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) OMA-1, (03)	
(23) OMA-1, (04)(d)	
(24) OMA-1, (05)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 641, Statutes of 1986, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 641, Statutes of 1986.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 641, Statutes of 1986, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

OPEN MEETINGS ACT Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form OMA-1 and enter the amount from line (10).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form OMA-1, line (10).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. OMA-1, (03), means the information is located on form OMA-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
OPEN MEETINGS ACT

For State Controller Use Only

(19) Program Number 00092
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) OMA-1, (03)	
(23) OMA-1, (04)(d)	
(24) OMA-1, (05)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 641, Statutes of 1986, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 641, Statutes of 1986.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 641, Statutes of 1986, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

OPEN MEETINGS ACT Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form OMA-1 and enter the amount from line (10).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form OMA-1, line (10).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. OMA-1, (03), means the information is located on form OMA-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PARENT CLASSROOM VISITS

For State Controller Use Only

(19) Program Number 00154
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) PCV-1, (03)(a)(1)	
(23) PCV-1, (03)(a)(2)	
(24) PCV-1, (03)(a)(3)	
(25) PCV-1, (03)(b)(1)	
(26) PCV-1, (03)(b)(2)	
(27) PCV-1, (03)(b)(3)	
(28) PCV-1, (04)(1)(d)	
(29) PCV-1, (04)(2)(d)	
(30) PCV-1, (04)(3)(d)	
(31) PCV-1, (04)(4)(d)	
(32) PCV-1, (06)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1284, Statutes of 1988 and Chapter 213, Statutes of 1989; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1284, Statutes of 1988 and Chapter 213, Statutes of 1989.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1284, Statutes of 1988 and Chapter 213, Statutes of 1989, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PARENT CLASSROOM VISITS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PCV-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PCV-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. PCV-1, (03)(a)(1), means the information is located on form PCV-1, line (03)(a)(1)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
LAW ENFORCEMENT AGENCY NOTIFICATION

For State Controller Use Only

(19) Program Number 00157
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	LEAN-1, (03)	
(23)	LEAN-1, (04)(1)(d)	
(24)	LEAN-1, (04)(2)(d)	
(25)	LEAN-1, (06)	
(26)		
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1117, Statutes of 1989, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1117, Statutes of 1989.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1117, Statutes of 1989, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

LAW ENFORCEMENT AGENCY NOTIFICATION Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form LEAN-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form LEAN-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. LEAN-1, (03), means the information is located on form LEAN-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
NOTIFICATION TO TEACHERS:
PUPILS SUBJECT TO SUSPENSION OR EXPULSION

For State Controller Use Only

(19) Program Number 00150
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) NTT-1, (03)(a)	
(23) NTT-1, (03)(b)	
(24) NTT-1, (03)(c)	
(25) NTT-1, (04)(1)(d)	
(26) NTT-1, (04)(2)(d)	
(27) NTT-1, (04)(3)(d)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1306, Statutes of 1989 and Chapter 1257, Statutes of 1993; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1306, Statutes of 1989 and Chapter 1257, Statutes of 1993.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1306, Statutes of 1989 and Chapter 1257, Statutes of 1993, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

NOTIFICATION TO TEACHERS: PUPILS SUBJECT TO SUSPENSION OR EXPULSION **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form NTT-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form NTT-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. NTT-1, (03)(a), means the information is located on form NTT-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

SCHOOL ACCOUNTABILITY REPORT CARDS

1. Summary of Chapters 1463/89 and 759/92

Education Code § 33126
Chapter 912, Statutes of 1997
Chapter 824, Statutes of 1994
Chapter 1031, Statutes of 1993

Education Code § 35256 and 35256.1
Chapter 824, Statutes of 1994
Chapter 1463, Statutes of 1989

Education Code 35258
Chapter 918, Statutes of 1997

Education Code § § 41409 and 41409.3
Chapter 759, Statutes of 1992
Chapter 1463, Statutes of 1989

Proposition 98, an initiative approved by California voters, requires schools in each school district to develop and issue school accountability report cards and set forth thirteen items to be included in these report cards. Statutes adopted after the approval of Proposition 98 added new subjects to be included in the school accountability report cards.

The Commission on State Mandates, in the Statement of Decision adopted at the April 28, 1998 hearing, determined that Education Code Sections 33126, 35256, 35256.1, 35258, 41409, and 41409.3, impose a reimbursable state mandated new program or higher level of service upon school districts within the meaning of section 6, article XIII B of the California Constitution and section 17514 of the Government Code.

2. Eligible Claimants

With the exception of community colleges, any school district (K-12) or county board of education that incurs increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Appropriations

These claiming instructions are issued following the adoption of the program's parameters and guidelines by the Commission on State Mandates. To determine if this program is funded in subsequent fiscal years, refer to the schedule, "Appropriation for State Mandated Cost Programs," in the *"Annual Claiming Instructions for State Mandated Costs"* issued in September of each year to county superintendents of schools and superintendents of schools.

4. Types of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement and/or an estimated claim. A reimbursement claim details the costs actually incurred for a prior fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year.

B. Minimum Claim

Government Code § 17564(a) provides that no claim shall be filed pursuant to Government Code § 17561 unless such a claim exceeds $200 per program per fiscal year. However, any county superintendent of schools, as fiscal agent for the school district, may submit a combined claim in excess of $200 on behalf of districts within the county even if an individual district's claim does not exceed $200. A combined claim

must show the individual costs for each district. Once a combined claim is filed, all subsequent years relating to the same mandate must be filed in a combined form. The county receives the reimbursement payment and is responsible for disbursing funds to each participating district. A district may withdraw from the combined claim form by providing a written notice to the county superintendent of schools and the State Controller's Office of its intent to file a separate claim, at least 180 days prior to the deadline for filing the claim.

5. Filing Deadline

A. Initial Claims

Pursuant to Government Code section 17561, subdivision (d)(3), initial claims must be filed within 120 days from the issuance of claiming instructions. Accordingly:

(1) Reimbursement claims detailing the actual costs incurred for the 1996-97 and 1997-98 fiscal years must be filed with the State Controller's Office and postmarked by February 24, 1999. If the reimbursement claim is filed after the deadline of February 24, 1999, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

(2) Estimated claims for costs to be incurred during the 1998-99 fiscal year must be filed with the State Controller's Office and postmarked by February 24, 1999. Timely filed estimated claims are paid before late claims. If a payment is received for the estimated claim, a 1998-99 reimbursement claim must be filed by January 15, 2000.

B. Annually Thereafter

Refer to item, "Reimbursable State Mandated Cost Programs," contained in the cover letter for mandated cost programs issued annually in October, which identifies the fiscal years for which claims may be filed. If an "x" is shown for the program listed under "19__/19__ Reimbursement Claim," and/or "19__/19__ Estimated Claim," claims may be filed as follows:

(1) An estimated claim filed with the State Controller's Office must be postmarked by January 15 of the fiscal year in which costs are to be incurred. Timely filed estimated claims will be paid before late claims.

After having received payment for an estimated claim, the claimant must file a reimbursement claim by January 15 of the following fiscal year. If the district fails to file a reimbursement claim, monies received for the estimated claim must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. For information regarding appropriations for reimbursement claims, refer to the schedule, "Appropriation for State Mandated Cost Programs" in the previous fiscal year's annual claiming instructions.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by January 15 following the fiscal year in which costs were incurred. If the claim is filed after the deadline but by January 15 of the succeeding fiscal year, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

6. Reimbursable Activities

For each eligible school district and county board of education, the direct and indirect costs of labor, supplies, and services incurred for the following mandated components are reimbursable:

A. Compilation, Analysis, and Reporting of Data

For the period beginning July 1, 1996, the cost of compilation and updating data, preparation of analyses, and the preparation of the new mandated provisions, items 12 to 19, added to the school accountability report cards (SARC's), as described below can be claimed.

(1) The degree to which pupils are prepared to enter the workforce;

(2) The total number of instructional minutes offered in the school year, separately stated for each grade level, as compared to the total number of the instructional minutes per school year required by state law, separately stated for each grade level;

(3) The total number of minimum days, as specified in Education Code sections 46112, 46113, 46117, and 46141 in the school year;

(4) The beginning, median, and highest paid to teachers in the district, as reflected in the district's salary scale;

(5) The average salary for school site principals in the district;

(6) The salary of the district superintendent;

(7) Based upon the state summary information provided by the Superintendent of Public Instruction pursuant to subdivision (b) of Education Code section 41409, the statewide average salary for the appropriate size and type of district for the following:

  (a) Beginning, mid-range, and highest salary paid to teachers;

  (b) school site principals; and

  (c) district superintendents

(8) The statewide average of the percentage school district expenditures allocated for the salaries of administrative personnel for the appropriate size and type of district for the most recent fiscal year, provided by the Superintendent of Public Instruction pursuant to subdivision (a) of section 41409 of the Education Code;

(9) The percentage allocated under the district's corresponding fiscal year expenditure for the salaries of administrative personnel, as defined in Education Code sections 1200, 1300, 1700, 1800, and 2200 of the California School Accounting Manual published by the State Department of Education;

(10) The statewide average of the percentage of school district expenditures allocated for the salaries of teachers for the appropriate size and type of district for the most recent fiscal year, provided by the Superintendent of Public Instruction, pursuant to subdivision (a) of section 41409 of the Education Code; and

(11) The percentage of the budget that is expended for the salaries of teachers, as defined in section 1100 of the *California School Accounting Manual* published by the State Department of Education.

For the period beginning January 1, 1998, the required data and analyses includes the reporting of the eleven items above plus the following district-wide and site-specific information:

(1) Results by grade level from the assessment tool used by the school district using percentiles when available for the most recent three-year period, including the pupil achievement by grade level as measured by the statewide assessment developed by the state pursuant to Chapter 5 (commencing with section 60600) and Chapter 6 (commencing with section 60800) of Part 33 of the Education Code:

(2) The average verbal and math Scholastic Achievement Test scores of high school seniors to the extent such scores are provided to the school and the average percentage of seniors taking that exam for the most recent three-year period;

(3) The one-year dropout rate listed in California Basic Education Data System for the school site over the most recent three-year period;

(4) The distribution of class sizes at the school site by grade level, the average class size, and the percentage of pupils in kindergarten and grades 1 to 3, inclusive, participating in the Class size Reduction Program established pursuant to Chapter 6.10 (commencing with section 52120) of part 28 of the Education Code, using California Basic Education Data System information for the most recent three-year period;

(5) The total number of the school's credentialed teachers, the number of teachers relying upon emergency credentials, and the number of teachers working without credentials for the most recent three-year period;

(6) Any assignment of teachers outside of their subject area of competence for the first two years of the most recent three-year period;

(7) The annual number of schooldays dedicated to staff development for the most recent three-year period; and

(8) The suspension and expulsion rates for the most recent three-year period.

B. Annual Posting of School Accountability Report Cards on the Internet

A school district is connected to the Internet if one or more of its schools or the administrative office has a dedicated line or dial-up account to the Internet. These school districts are eligible for reimbursement as follows:

(1) School districts with district or individual school web sites are eligible to be reimbursed for the following activities in compliance with this mandate:

(a) One-time costs to add web pages for each school to the district web site or individual school web sites to post school accountability report card (SARC) information. School districts are eligible to claim one-time costs to add web pages for new schools on subsequent claims.

(b) One-time costs to purchase other software limited to a pro rata portion of newly purchased software used to prepare the SARC.

(c) Ongoing costs to annually post the SARC information on the district's web site or on individual school web sites.

(d) Ongoing costs to maintain electronic media storage space for the district's web site and individual school sites for posting the SARC information.

(e) Ongoing costs to purchase software specifically to convert the SARC to a file format capable of being posted on the Internet.

(f) Ongoing costs to annually convert the SARC information described in 6A. to formats capable of being posted on the district's web site or on individual school web sites.

(2) School districts without web sites on January 1, 1998, are eligible to be reimbursed for the following activities in compliance with this mandate:

(a) One-time costs to establish one web site for the district to post the SARC information described in 6A and to purchase other software, limited to a pro rata portion of newly purchased software used to prepare the SARC.

(b) One-time costs to develop and add web pages to post SARC information for each school. School districts are eligible to claim one-time costs to add web pages for new schools on subsequent claims.

(c) Ongoing costs to convert the SARC information to formats capable of being posted on the district's web site or on individual school web sites.

(d) Ongoing costs to annually post SARC information on the district's web site or on individual school web sites.

(e) Ongoing costs to maintain electronic media storage space for the district's web site and individual school web sites for posting the SARC information.

(f) Ongoing costs to purchase software specifically to convert the SARC to a file format capable of being posted on the Internet.

7. Reimbursement Limitations

A. School districts shall not be reimbursed for establishing an Internet connection nor for maintaining Internet access and shall not be reimbursed for the establishment of web sites for individual schools.

B. Any offsetting savings or reimbursement the claimant received from any source including but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate, shall be identified and deducted so only net local costs are claimed.

8. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms SARC-1 and SARC-2 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary. In such instances, new replacement forms will be mailed to claimants.

A. Form SARC-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form SARC-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits. In lieu of actual hours, the average number of hours devoted to each reimbursable activity may be claimed if supported by a documented time study. At present no instructions are available for performing a time study. Therefore, it is suggested that claims be based on actual costs.

Reimbursement for personal services include compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure. If a documented time study is the basis for claimed time spent, attach the time records with the claim. The State Controller's Office will review the time study for precision and reliability.

(2) Materials and Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of contractor(s) who performed the service(s), including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor, and give the number of actual hours spent on the activities, if applicable. Show the actual dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the expenditure.

(4) Equipment

List the cost of equipment and other capital assets acquired for the purpose of this mandate. Explain the use of each type of equipment. Leased equipment (with an option to purchase), are considered purchases. The cost of the equipment cannot be expensed for the year of purchase, unless permitted by the Commission on State Mandates. Only the equipment's yearly depreciated value using the straight-line method may be claimed. The Internal Revenue Service *"Publication 946"* may be used to obtain an estimated useful life of the equipment. If the equipment is acquired for the subject state mandate, but is utilized in some way not directly related to the program, only the pro-rated portion of the equipment that is used for purposes of this program is reimbursable.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the purchases.

(5) Travel Expenses

Travel expenses for mileage, per diem, lodging and other employee entitlements are reimbursable in accordance with the rules of the local jurisdiction. Provide the name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination points and costs.

Source documents may include, but are not limited to, employee travel expense claims, receipts, and other documents evidencing the travel expenses.

(6) Training

The cost of training specified in Section 6, Reimbursable Activities, are reimbursable. Give the class title, dates, location, and name(s) of the employee(s) attending training associated with the mandate. Reimbursable costs include, but are not limited to, salaries and benefits of personnel conducting or attending the training, registration fees, transportation, lodging, and per diem.

Source documents may include, but are not limited to, employee travel expense claims, receipts, and other documents evidencing the training expenses.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial claim at the time the claim was filed, supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

B. Form SARC-1, Claim Summary

This form is used to summarize direct costs by claim component and compute allowable indirect costs for the mandate.

School districts and local boards of education may compute the amount of indirect costs utilizing the State Department of Education's Annual Program Cost Data Report J-380 or J-580 rate, as applicable. The cost data on this form is carried forward to form FAM-27.

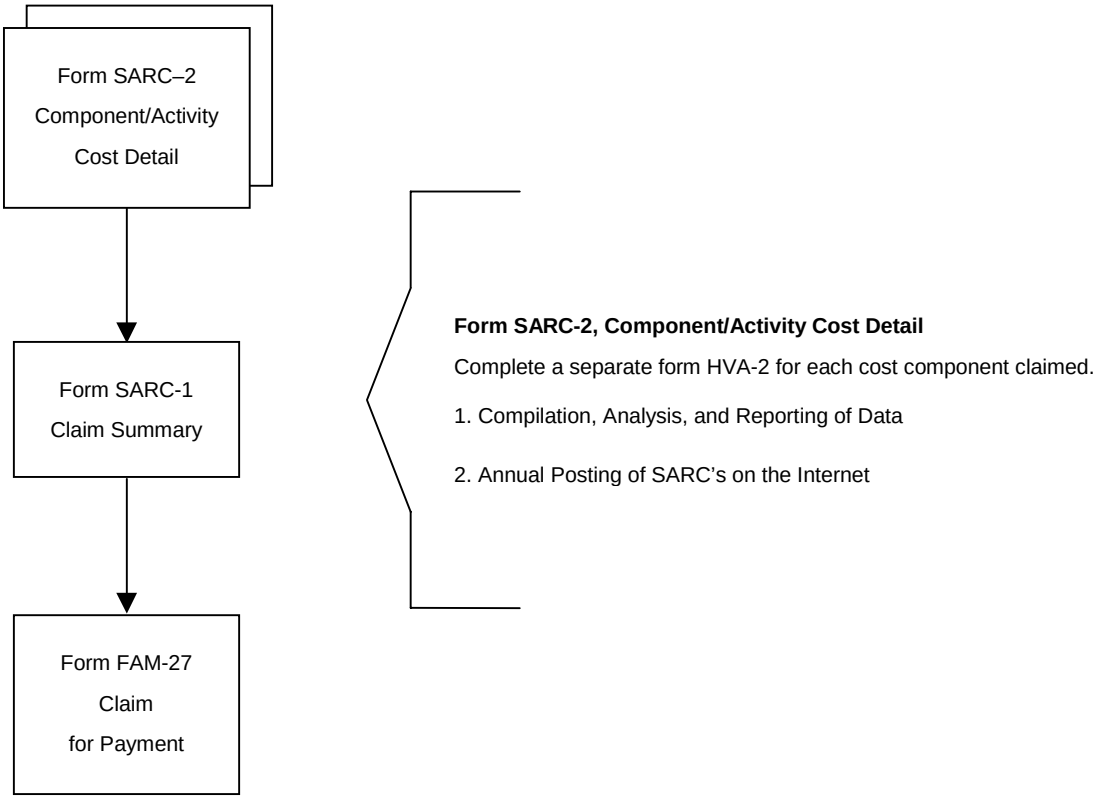
C. Form FAM-27, Claim for Payment

Form FAM-27 contains a certification that must be signed by an authorized representative of the district. All applicable information from form SARC-1 must be carried forward to this form for the State Controller's Office to process the claim for payment.

D. Cost Accounting Statistics

The Commission on State Mandates requests that claimants send a copy of form SARC-1 for the initial year's reimbursement claims by mail or facsimile to the Commission on State Mandates, 1300 I Street, Suite 950, Sacramento, CA 95814, Facsimile: (916) 445-0278. Although providing this information is not a condition of payment, claimants are encouraged to provide this information to enable the Commission to develop a statewide cost estimate and recommend an appropriation to the Legislature.

Illustration of Forms



CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SCHOOL ACCOUNTABILITY REPORT CARDS

For State Controller Use Only

(19) Program Number 00171
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	SARC-1, (03)	
(23)	SARC-1, (04)(1)(f)	
(24)	SARC-1, (04)(2)(f)	
(25)	SARC-1, (06)	
(26)		
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1463, Statutes of 1989, and Chapter 759, Statutes of 1992, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1463, Statutes of 1989, and Chapter 759, Statutes of 1992.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1463, Statutes of 1989, and Chapter 759, Statutes of 1992, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SCHOOL ACCOUNTABILITY REPORT CARDS Certification Claim Form Instructions	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SARC-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SARC-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. SARC-1, (03), means the information is located on form SARC-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS **SCHOOL ACCOUNTABILITY REPORT CARDS** **CLAIM SUMMARY**	**FORM SARC-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

Claim Statistics

(03) Leave blank.

Direct Costs	**Object Accounts**					
(04) Reimbursable Components	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Travel and Training	(d) Equipment	(e) Contract Services	(f) Total
1. Compilation, Analysis, and Reporting Data						
2. Annual Posting of SARC's on the Internet						
(05) Total Direct Costs						

Indirect Costs

(06) Indirect Cost Rate	[From J-380 or J-580]	%
(07) Total Indirect Costs	[Line (06) x line (05)(f)]	
(08) Total Direct and Indirect Costs	[Line (05)(f) + line (07)]	

Cost Reduction

(09) Less: Offsetting Savings, if applicable		
(10) Less: Other Reimbursements, if applicable		
(11) Total Claimed Amount	[Line (08) – {line (09) + line (10)}]	

SCHOOL ACCOUNTABILITY REPORT CARDS CLAIM SUMMARY Instructions	FORM SARC-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form SARC-1 must be filed for a reimbursement claim. Do not complete form SARC-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form SARC-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Leave blank.

(04) Reimbursable Components. For each reimbursable component, enter the total from form SARC-2, line (05), columns (d), (e), (f), and (g) to form SARC-1, block (04), columns (a), (b), (c), (d), and (e) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (f).

(06) Indirect Cost Rate. Enter the indirect cost rate from the Department of Education form J-380 or J-580, as applicable for the fiscal year of costs.

(07) Total Indirect Costs. Enter the result of multiplying the Indirect Cost Rate, line (06), by the Total Direct Costs, line (05)(f).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(f), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS **SCHOOL ACCOUNTABILITY REPORT CARDS** **COMPONENT/ACTIVITY COST DETAIL**	**FORM** **SARC-2**

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Check only **one** box per form to identify the component being claimed.

☐ Compilation, Analysis, and Reporting Data ☐ Annual Posting of SARC's on the Internet

(04) Description of Expenses: Complete columns (a) through (h). **Object Accounts**

(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries and Benefits	(e) Materials and Supplies	(f) Travel and Training	(g) Equipment	(h) Contract Services
(05) Total ☐ Subtotal ☐ Page:____of____							

SCHOOL ACCOUNTABILITY REPORT CARDS COMPONENT/ACTIVITY COST DETAIL Instructions	**FORM SARC-2**

(01) Enter the name of the claimant.

(02) No entry required.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form SARC-2 shall be prepared for each applicable component.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services, travel expenses, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial payment at the time the claim was filed, supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	**Columns**								**Submit these supporting documents with the claim**
	(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	**(g)**	**(h)**	
Salaries	Employee Name Title Activities	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked					
Benefits		Benefit Rate		Benefits = Benefit Rate x Salaries					
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used		Cost = Unit Cost x Quantity Used				
Travel and Training Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode			Total Travel Cost = Rate x Days or Miles			
Training	Employee Name/Title Name of Class		Dates Attended			Registration Fee			
Equipment	Description of Equipment Purchased Equipment ID	Unit Cost	Quantity Used				Itemized Cost of Equipment Purchased		Invoice
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service					Itemized Cost of Services Performed	Invoice

(05) Total line (04), columns (d), (e), (f), (g), and (h) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Enter totals from line (05), columns (d), (e), (f), (g), and (h) to form SARC-1, block (04), columns (a), (b), (c), (d) and (e) in the appropriate row.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
AIDS PREVENTION INSTRUCTION

For State Controller Use Only

(19) Program Number 00123
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	PI-1, (03)	
(23)	PI-1, (04)(1)(d)	
(24)	PI-1, (04)(2)(d)	
(25)	PI-1, (06)	
(26)		
(27)		
(28)		
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 818, Statutes of 1991, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 818, Statutes of 1991.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 818, Statutes of 1991, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

AIDS PREVENTION INSTRUCTION Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PI-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PI-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. PI-1, (03), means the information is located on form PI-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
CHARTER SCHOOLS

For State Controller Use Only

(19) Program Number 00140
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data	
(22) CS-1, (03)	
(23) CS-1, (04)(1)(d)	
(24) CS-1, (04)(2)(d)	
(25)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 781, Statutes of 1992, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 781, Statutes of 1992.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 781, Statutes of 1992, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

CHARTER SCHOOLS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CS-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CS-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. CS-1, (03), means the information is located on form CS-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
THREATS AGAINST PEACE OFFICERS

For State Controller Use Only

(19) Program Number 00163
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) TAP-1, (03)			
(23) TAP-1, (04)(1)(e)			
(24) TAP-1, (04)(2)(e)			
(25) TAP-1, (06)			
(26)			
(27)			
(28)			
(29)			
(30)			
(31)			
(32)			
(33)			
(34)			
(35)			
(36)			
(37)			

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 1249, Statutes of 1992 and Chapter 666, Statutes of 1995 and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 1249, Statutes of 1992 and Chapter 666, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 1249, Statutes of 1992 and Chapter 666, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

THREATS AGAINST PEACE OFFICERS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form TAP-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an " X " in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X " in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form TAP-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim e.g. TAP-1, (03), means the information is located on form TAP-1, line (03). Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 35% should be shown as 35). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
SCHOOL DISTRICT OF CHOICE: TRANSFERS AND APPEALS

For State Controller Use Only

(19) Program Number 00156
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

Type of Claim	**Estimated Claim**	**Reimbursement Claim**	
	(03) Estimated ☐	(09) Reimbursement ☐	(22) SDC-1, (03)(a)
	(04) Combined ☐	(10) Combined ☐	(23) SDC-1, (03)(b)
	(05) Amended ☐	(11) Amended ☐	(24) SDC-1, (03)(c)
			(25) SDC-1, (03)(d)
			(26) SDC-1, (03)(e)
			(27) SDC-1, (04)(1)(d)
			(28) SDC-1, (04)(2)(d)
			(29) SDC-1, (04)(3)(d)
			(30) SDC-1, (04)(4)(d)
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___	(31) SDC-1, (04)(5)(d)
Total Claimed Amount	(07)	(13)	(32) SDC-1, (06)
Less: **10% Late Penalty, not to exceed $1,000**		(14)	(33)
Less: **Estimated Claim Payment Received**		(15)	(34)
Net Claimed Amount		(16)	(35)
Due from State	(08)	(17)	(36)
Due to State		(18)	(37)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 160, Statutes of 1993 and Chapter 1262, Statutes of 1994; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 160, Statutes of 1993 and Chapter 1262, Statutes of 1994.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 160, Statutes of 1993 and Chapter 1262, Statutes of 1994, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

SCHOOL DISTRICT OF CHOICE: TRANSFERS AND APPEALS **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form SDC-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form SDC-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. SDC-1, (03)(a), means the information is located on form SDC-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
INTRADISTRICT ATTENDANCE

For State Controller Use Only

(19) Program Number 00153
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) IDA-1, (03)(a)	
(23) IDA-1, (03)(b)	
(24) IDA-1, (03)(c)	
(25) IDA-1, (04)(1(d))	
(26) IDA-1, (04)(2)(d)	
(27) IDA-1, (04)(3)(d)	
(28) IDA-1, (04)(4)(d)	
(29) IDA-1, (06)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 161, Statutes of 1993 and Chapter 915, Statutes of 1993; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 161, Statutes of 1993 and Chapter 915, Statutes of 1993.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 161, Statutes of 1993 and Chapter 915, Statutes of 1993, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

INTRADISTRICT ATTENDANCE Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form IDA-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form IDA-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. IDA-1, (03)(a), means the information is located on form IDA-1, line (03)(a)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

Caregiver Affidavits

1. Summary of Chapter 98, Statutes of 1994

Education Code section 48204, subdivision (d), as added by Chapter 98, Statutes of 1994, requires school districts to enroll a pupil if the pupil lives in the home of a caregiving adult who resides within the boundaries of the school district. Family Code sections 6550 and 6552 set forth the form of caregiver affidavit to be used to establish residence for school attendance of a pupil and provides that a caregiver affidavit shall not be valid for more than one year.

The Commission on State Mandates, in the Statement of Decision adopted at the May 28, 1998 hearing, determined that Education Code section 48204, subdivision (d), and Family Code sections 6550 and 6552, impose a reimbursable state mandated new program or higher level of service upon school districts within the meaning of section 6, article XIII B of the California Constitution and section 17514 of the Government Code.

2. Eligible Claimants

Any school district (K-12) or county board of education that incurs increased costs as a direct result of this mandate is eligible to claim reimbursement of these costs.

3. Appropriations

These claiming instructions are issued following the adoption of the program's parameters and guidelines by the Commission on State Mandates. Funding for payment of initial claims covering fiscal years 1994-95, 1995-96, 1996-97, and 1997-98, may be made available in a future appropriation act subject to the approval of the Legislature and the Governor.

To determine if this program is funded in subsequent fiscal years, refer to the schedule, "Appropriation for State Mandated Cost Programs," in the *"Annual Claiming Instructions for State Mandated Costs"* issued in October of each year to county superintendents of schools and superintendents of schools.

4. Types of Claims

A. Reimbursement and Estimated Claims

A claimant may file a reimbursement and/or an estimated claim. A reimbursement claim details the costs actually incurred for a prior fiscal year. An estimated claim shows the costs to be incurred for the current fiscal year.

B. Minimum Claim

Government Code § 17564(a) provides that no claim shall be filed pursuant to Government Code § 17561 unless such a claim exceeds $200 per program per fiscal year. However, any county superintendent of schools, as fiscal agent for the school district, may submit a combined claim in excess of $200 on behalf of one or more districts within the county even if the individual district's claim does not exceed $200. A combined claim must show the individual costs for each district. Once a combined claim is filed, all subsequent years relating to the same mandate must be filed in a combined form. The county receives the reimbursement payment and is responsible for disbursing funds to each participating district. A district may withdraw from the combined claim form by providing a written notice to the county superintendent of schools and the State Controller's Office of its intent to file a separate claim, at least 180 days prior to the deadline for filing the claim.

5. Filing Deadline

A. Initial Claims

Pursuant to Government Code section 17561, subdivision (d)(3), initial claims must be filed within 120 days from the issuance of claiming instructions. Accordingly:

(1) Reimbursement claims detailing the actual costs incurred for the 1994-95, 1995-96, 1996-97, and 1997-98 fiscal years must be filed with the State Controller's Office and postmarked by February 24, 1999. If the reimbursement claim is filed after the deadline of February 24, 1999, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

(2) Estimated claims for costs to be incurred during the 1998-99 fiscal year must be filed with the State Controller's Office and postmarked by February 24, 1999. Timely filed estimated claims are paid before late claims. If a payment is received for the estimated claim, a 1998-99 reimbursement claim must be filed by January 15, 2000.

B. Annually Thereafter

Refer to the item, "Reimbursable State Mandated Cost Programs", contained in the cover letter for mandated cost programs issued annually in October, which identifies the fiscal years for which claims may be filed. If an "x" is shown for the program listed under "19__/19__ Reimbursement Claim", and/or "19__/19__ Estimated Claim", claims may be filed as follows:

(1) An estimated claim filed with the State Controller's Office must be postmarked by January 15 of the fiscal year in which costs are to be incurred. Timely filed estimated claims will be paid before late claims.

After having received payment for an estimated claim, the claimant must file a reimbursement claim by January 15 of the following fiscal year. If the district fails to file a reimbursement claim, monies received for the estimated claim must be returned to the State. If no estimated claim was filed, the agency may file a reimbursement claim detailing the actual costs incurred for the fiscal year, provided there was an appropriation for the program for that fiscal year. For information regarding appropriations for reimbursement claims, refer to the schedule, "Appropriation for State Mandated Cost Programs" in the previous fiscal year's annual claiming instructions.

(2) A reimbursement claim detailing the actual costs must be filed with the State Controller's Office and postmarked by January 15 following the fiscal year in which costs were incurred. If the claim is filed after the deadline but by January 15 of the succeeding fiscal year, the approved claim must be reduced by a late penalty of 10%, not to exceed $1,000. Claims filed more than one year after the deadline will not be accepted.

6. Reimbursable Activities

For each eligible school district and county board of education, the direct and indirect costs of labor, supplies, and services incurred for the following mandated components are reimbursable:

A. Preparation and Adoption of Policies, Procedures, and Forms

(1) The one-time activity of preparing, amending, and adopting policies, procedures, and forms (other than the caregiver affidavit form) to implement the mandated program. This includes forms related to the enrollment of pupils to incorporate provisions referring to caregiver affidavits and enrollment on caregiver status.

(2) Incorporating the statutory caregiver affidavit form into other school district policies, procedures, and forms.

B. Annual Acceptance and Approval of Caregiver Affidavits and Monitoring Students

(1) The continuing activity of accepting and reviewing for completeness the caregiver affidavit form submitted by the caregiver on an annual basis. This includes the review of the caregiver affidavits upon receipt to verify completion of items one through four (1- 4) and the signature line on the form.

(2) The continuing activity of monitoring and tracking students enrolled under a caregiver affidavit for annual expiration and renewal of the affidavit.

C. Administrative Tasks Associated with Enrollment and Transfers

The continuing activity of performing administrative tasks associated with enrollment and transfer of students under the caregiver affidavit program.

D. Training

Activities associated with training school district personnel about the requirements related to the enrollment of pupils living with caregivers are eligible for reimbursement. This component includes, but is not limited to, the labor time of administrators and other school district personnel involved with the preparation of training sessions and conduct or attend training sessions. The cost of materials and supplies used or distributed in training sessions is eligible for reimbursement.

(1) The one-time activity of developing training regarding the requirements of the subject mandate.

(2) The continuing activity of conducting and attending training regarding the requirements of the subject mandate.

7. Reimbursement Limitations

Any offsetting savings or reimbursement the claimant received from any source including, but not limited to, service fees collected, federal funds, and other state funds as a direct result of this mandate shall be identified and deducted so only net local costs are claimed.

8. Claiming Forms and Instructions

The diagram "Illustration of Claim Forms" provides a graphical presentation of forms required to be filed with a claim. A claimant may submit a computer generated report in substitution for forms CA-1 and CA-2 provided the format of the report and data fields contained within the report are identical to the claim forms included in these instructions. The claim forms provided with these instructions should be duplicated and used by the claimant to file estimated or reimbursement claims. The State Controller's Office will revise the manual and claim forms as necessary. In such instances, new replacement forms will be mailed to claimants.

A. Form CA-2, Component/Activity Cost Detail

This form is used to segregate the detailed costs by claim component. A separate form CA-2 must be completed for each cost component being claimed. Costs reported on this form must be supported as follows:

(1) Salaries and Benefits

Identify the employee(s), and/or show the classification of the employee(s) involved. Describe the mandated functions performed and specify the actual time devoted to each function by each employee, productive hourly rate, and related fringe benefits. In lieu of actual hours, the average number of hours devoted to each reimbursable activity may be claimed if supported by a documented time study. At present no instructions are available for performing a time study. Therefore, it is suggested that claims be based on actual costs.

Reimbursement for personal services include compensation paid for salaries, wages, and employee fringe benefits. Employee fringe benefits include regular compensation paid to an

employee during periods of authorized absences (e.g., annual leave, sick leave) and the employer's contribution of social security, pension plans, insurance, and worker's compensation insurance. Fringe benefits are eligible for reimbursement when distributed equitably to all job activities which the employee performs.

Source documents may include, but are not limited to, time logs evidencing actual costs claimed under Reimbursable Activities, time sheets, payroll records, canceled payroll warrants, organization charts, duty statements, pay rate schedules, and other documents evidencing the expenditure. If a documented time study is the basis for claimed time spent, attach the time records with the claim. The State Controller's Office will review the time study for precision and reliability.

(2) Materials and Supplies

Only expenditures that can be identified as a direct cost of this mandate may be claimed. List the cost of materials and supplies consumed specifically for the purposes of this mandate. Purchases shall be claimed at the actual price after deducting cash discounts, rebates, and allowances received by the claimant. Supplies that are withdrawn from inventory shall be charged based on a recognized method of costing, consistently applied.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the expenditure.

(3) Contract Services

Provide the name(s) of contractor(s) who performed the service(s), including any fixed contracts for services. Describe the reimbursable activity(ies) performed by each named contractor, and give the number of actual hours spent on the activities, if applicable. Show the actual dates when services were performed and itemize all costs for those services. Attach consultant invoices with the claim.

Source documents may include, but are not limited to, general and subsidiary ledgers, contracts, invoices, canceled warrants, and other documents evidencing the expenditure.

(4) Equipment

List the cost of equipment and other capital assets acquired for the purpose of this mandate. Explain the use of each type of equipment. Leased equipment (with an option to purchase), are considered purchases. If the equipment is acquired for the subject state mandate, but is utilized in some way not directly related to the program, only the pro-rated portion of the equipment that is used for purposes of this program is reimbursable.

Source documents may include, but are not limited to, general and subsidiary ledgers, invoices, purchase orders, receipts, canceled warrants, inventory records, and other documents evidencing the purchases.

(5) Travel Expenses

Travel expenses for mileage, per diem, lodging, and other employee entitlements are reimbursable in accordance with the rules of the local jurisdiction. Provide the name(s) of the traveler(s), purpose of travel, inclusive travel dates, destination points and costs.

Source documents may include, but are not limited to, employee travel expense claims, receipts, and other documents evidencing the travel expenses.

(6) Training

The cost of training specified in Section 6, Reimbursable Activities, are reimbursable. Give the class title, dates, location, and name(s) of the employee(s) attending training associated with the mandate. Reimbursable costs include, but are not limited to, salaries and benefits of

personnel conducting or attending the training, registration fees, transportation, lodging, and per diem.

Source documents may include, but are not limited to, employee travel expense claims, receipts, and other documents evidencing the training expenses.

For audit purposes, all supporting documents must be retained for a period of two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial claim at the time the claim was filed, supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

B. Form CA-1, Claim Summary

This form is used to summarize direct costs by claim component and compute allowable indirect costs for the mandate. Claim statistics shall identify the work performed for costs claimed. School districts must give the number of caregiver affidavits filed in the fiscal year of claim.

School districts and local boards of education may compute the amount of indirect costs utilizing the State Department of Education's Annual Program Cost Data Report J-380 or J-580 rate, as applicable. The cost data on this form is carried forward to form FAM-27.

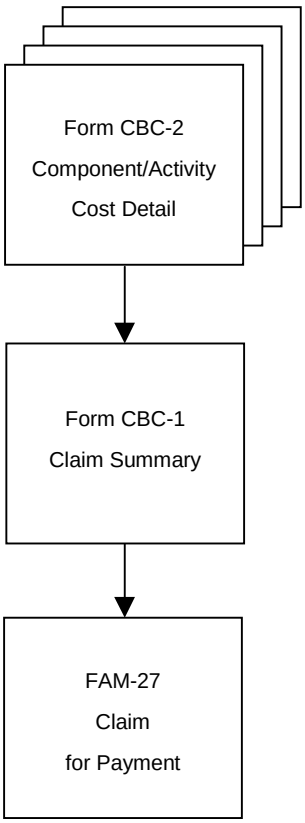
C. Form FAM-27, Claim for Payment

Form FAM-27 contains a certification that must be signed by an authorized representative of the district. All applicable information from form CA-1 must be carried forward to this form for the State Controller's Office to process the claim for payment.

D. Cost Accounting Statistics

The Commission on State Mandates requests that claimants send a copy of form CA-1 for the initial year's reimbursement claims by mail or facsimile to the Commission on State Mandates, 1300 I Street, Suite 950, Sacramento, CA 95814, Facsimile: (916) 445-0278. Although providing this information is not a condition of payment, claimants are encouraged to provide this information to enable the Commission to develop a statewide cost estimate and recommend an appropriation to the Legislature.

Illustration of Forms



Form CA-2, Component/Activity Cost Detail
Complete a separate form CA-2 for each cost component for which expenses are claimed.

1. Preparation and Adoption of Policies and Forms
2. Annual Acceptance and Approval of Caregiver Affidavits and Monitoring Students
3. Administrative Tasks Associated with Enrollment and Transfers
4. Training

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
CAREGIVER AFFIDAVITS

For State Controller Use Only

(19) Program Number 00172
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22) CA-1, (03)	
(23) CA-1, (04)(1)(f)	
(24) CA-1, (04)(2)(f)	
(25) CA-1, (04)(3)(f)	
(26) CA-1, (04)(4)(f)	
(27) CA-1, (06)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 98, Statutes of 1994, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 98, Statutes of 1994.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 98, Statutes of 1994, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

CAREGIVER AFFADAVITS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form CA-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form CA-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. CA-1, (03), means the information is located on form CA-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

MANDATED COSTS CAREGIVER AFFIDAVITS CLAIM SUMMARY	**FORM CA-1**

(01) Claimant	(02) Type of Claim	Fiscal Year
	Reimbursement ☐	
	Estimated ☐	19___/20___

(03) Number of caregiver affidavits filed in year of claim	

Direct Costs	**Object Accounts**					
(04) Reimbursable Components	(a) Salaries and Benefits	(b) Materials and Supplies	(c) Travel and Training	(d) Equipment	(e) Contract Services	(f) Total
1. Preparation and Adoption of Policies, Procedures and Forms						
2. Annual Acceptance and Approval of Caregiver Affidavits and Monitoring Students						
3. Administrative Tasks Associated with Enrollment and Transfers						
4. Training						
(05) Total Direct Costs						

Indirect Costs		
(06) Indirect Cost Rate	[From J-380 or J-580]	%
(07) Total Indirect Costs	[Line (06) x line (05)(f)]	
(08) Total Direct and Indirect Costs	[Line (05)(f) + line (07)]	

Cost Reduction	
(09) Less: Offsetting Savings, if applicable	
(10) Less: Other Reimbursements, if applicable	
(11) Total Claimed Amount [Line (08) – {line (09) + line (10)}]	

CAREGIVER AFFIDAVITS CLAIM SUMMARY Instructions	FORM CA-1

(01) Enter the name of the claimant.

(02) Type of Claim. Check a box, Reimbursement or Estimated, to identify the type of claim being filed. Enter the fiscal year of costs.

Form CA-1 must be filed for a reimbursement claim. Do not complete form CA-1 if you are filing an estimated claim and the estimate does not exceed the previous fiscal year's actual costs by more than 10%. Simply enter the amount of the estimated claim on form FAM-27, line (07). However, if the estimated claim exceeds the previous fiscal year's actual costs by more than 10%, form CA-1 must be completed and a statement attached explaining the increased costs. Without this information the high estimated claim will automatically be reduced to 110% of the previous fiscal year's actual costs.

(03) Enter the number of caregiver affidavits that were filed in the fiscal year of claim.

(04) Reimbursable Components. For each reimbursable component, enter the total from form CA-2, line (05), columns (d), (e), (f), (g), and (h) to form CA-1, block (04), columns (a), (b), (c), (d), and (e) in the appropriate row. Total each row.

(05) Total Direct Costs. Total columns (a) through (f).

(06) Indirect Cost Rate. Enter the indirect cost rate from the Department of Education form J-380 or J-580, as applicable for the fiscal year of costs.

(07) Total Indirect Costs. Enter the result of multiplying the Indirect Cost Rate, line (06), by the Total Direct Costs, line (05)(f).

(08) Total Direct and Indirect Costs. Enter the sum of Total Direct Costs, line (05)(f), and Total Indirect Costs, line (07).

(09) Less: Offsetting Savings, if applicable. Enter the total savings experienced by the claimant as a direct result of this mandate. Submit a detailed schedule of savings with the claim.

(10) Less: Other Reimbursements, if applicable. Enter the amount of other reimbursements received from any source including, but not limited to, service fees collected, federal funds, and other state funds, which reimbursed any portion of the mandated cost program. Submit a schedule detailing the reimbursement sources and amounts.

(11) Total Claimed Amount. Subtract the sum of Offsetting Savings, line (09), and Other Reimbursements, line (10), from Total Direct and Indirect Costs, line (08). Enter the remainder on this line and carry the amount forward to form FAM-27, line (07) for the Estimated Claim or line (13) for the Reimbursement Claim.

MANDATED COSTS
CAREGIVER AFFIDAVITS
COMPONENT/ACTIVITY COST DETAIL

FORM CA-2

(01) Claimant

(02) Fiscal Year Costs Were Incurred

(03) Reimbursable Component: Check only **one** box per form to identify the component being claimed.

☐ Preparation and Adoption of Policies, Procedures, and Forms ☐ Administrative Tasks

☐ Annual Acceptance and Approval of Caregiver Affidavits and Monitoring Students ☐ Training

(04) Description of Expenses: Complete columns (a) through (h). **Object Accounts**

(a) Employee Names, Job Classifications, Functions Performed, and Description of Expenses	(b) Hourly Rate or Unit Cost	(c) Hours Worked or Quantity	(d) Salaries and Benefits	(e) Materials and Supplies	(f) Contract Services	(g) Equipment	(h) Contract Services
(05) Total ☐ Subtotal ☐ Page:____of____							

CAREGIVER AFFIDAVITS COMPONENT/ACTIVITY COST DETAIL Instructions	**FORM CA-2**

(01) Enter the name of the claimant.

(02) Enter the fiscal year for which costs were incurred.

(03) Reimbursable Components. Check the box which indicates the cost component being claimed. Check only one box per form. A separate form CA-2 shall be prepared for each applicable component.

(04) Description of Expenses. The following table identifies the type of information required to support reimbursable costs. To detail costs for the component activity box "checked" in block (03), enter the employee names, position titles, a brief description of the activities performed, actual time spent by each employee, productive hourly rates, fringe benefits, supplies used, contract services, travel expenses, etc. **The descriptions required in column (4)(a) must be of sufficient detail to explain the cost of activities or items being claimed.** For audit purposes, all supporting documents must be retained by the claimant for a period of not less than two years after the end of the calendar year in which the reimbursement claim was filed or last amended, whichever is later. When no funds are appropriated for the initial payment at the time the claim was filed, supporting documents must be retained for two years from the date of initial payment of the claim. Such documents shall be made available to the State Controller's Office on request.

Object/ Sub object Accounts	**Columns**								**Submit these supporting documents with the claim**
	(a)	**(b)**	**(c)**	**(d)**	**(e)**	**(f)**	**(g)**	**(h)**	
Salaries	Employee Name Title Activities	Hourly Rate	Hours Worked	Salaries = Hourly Rate x Hours Worked					
Benefits		Benefit Rate		Benefits = Benefit Rate x Salaries					
Materials and Supplies	Description of Supplies Used	Unit Cost	Quantity Used		Cost = Unit Cost x Quantity Used				
Travel and Training Travel	Purpose of Trip Name and Title Departure and Return Date	Per Diem Rate Mileage Rate Travel Cost	Days Miles Travel Mode			Total Travel Cost = Rate x Days or Miles			
Training	Employee Name/Title Name of Class		Dates Attended			Registration Fee			
Equipment	Description of Equipment Purchased Equipment ID	Unit Cost	Quantity Used				Itemized Cost of Equipment Purchased		Invoice
Contract Services	Name of Contractor Specific Tasks Performed	Hourly Rate	Hours Worked Inclusive Dates of Service					Itemized Cost of Services Performed	Invoice

(05) Total line (04), columns (d), (e), (f), (g), and (h) and enter the sum on this line. Check the appropriate box to indicate if the amount is a total or subtotal. If more than one form is needed to detail the component/activity costs, number each page. Enter totals from line (05), columns (d), (e), (f), (g), and (h) to form CA-1, block (04), columns (a), (b), (c), (d) and (e) in the appropriate row.

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
INVESTMENT REPORTS

For State Controller Use Only

(19) Program Number 00169
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) INR-1, (03)	
(23) INR-1, (04)(1)(f)	
(24) INR-1, (04)(2)(f)	
(25) INR-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 783, Statutes of 1995, Chapter 156, Statutes of 1996, and Chapter 749, Statutes of 1996; and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 783, Statutes of 1995, Chapter 156, Statutes of 1996, and Chapter 749, Statutes of 1996.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 783, Statutes of 1995, Chapter 156, Statutes of 1996, and Chapter 749, Statutes of 1996, set forth on the attached statements.

Signature of Authorized Representative Date

_____ _____

_____ _____

Type or Print Name Title

(39) Name of Contact Person for Claim

Telephone Number (_____) _____ _____ Ext. _____

_____ E-mail Address _____

INVESTMENT REPORTS **Certification Claim Form** **Instructions**	**FORM** **FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form INR-1 and enter the amount from line (11). If more than one form INR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form INR-1.

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form INR-1, line (11). If more than one form INR-1 is completed due to multiple department involvement in this mandate, add line (11) of each form INR-1.

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. INR-1, (03), means the information is located on form INR-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
PHYSICAL PERFORMANCE TESTS

For State Controller Use Only

(19) Program Number 00173
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Type of Claim	Estimated Claim	Reimbursement Claim
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

Reimbursement Claim Data

(22)	PPT-1, (03)	
(23)	PPT-1, (04)(1)(f)	
(24)	PPT-1, (04)(2)(f)	
(25)	PPT-1, (04)(3)(f)	
(26)	PPT-1, (04)(4)(f)	
(27)	PPT-1, (04)(5)(f)	
(28)	PPT-1, (06)	
(29)		
(30)		
(31)		
(32)		
(33)		
(34)		
(35)		
(36)		
(37)		

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 975, Statutes of 1995, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 975, Statutes of 1995.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 975, Statutes of 1995, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

PHYSICAL PERFORMANCE TESTS Certification Claim Form Instructions	FORM FAM-27

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form PPT-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form PPT-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. PPT-1, (03), means the information is located on form PPT-1, line (03)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

CLAIM FOR PAYMENT
Pursuant to Government Code Section 17561
AMERICAN GOVERNMENT COURSE
DOCUMENT REQUIREMENTS

For State Controller Use Only

(19) Program Number 00179
(20) Date File _____/_____/_____
(21) LRS Input _____/_____/_____

LABEL HERE

(01) Claimant Identification Number

(02) Mailing Address

Claimant Name

County of Location

Street Address or P.O. Box

City State Zip Code

Reimbursement Claim Data

(22) AGDR-1, (04)(1)(f)	
(23) AGDR-1, (04)(2)(f)	
(24) AGDR-1, (04)(3)(f)	
(25) AGDR-1, (06)	
(26)	
(27)	
(28)	
(29)	
(30)	
(31)	
(32)	
(33)	
(34)	
(35)	
(36)	
(37)	

Type of Claim	**Estimated Claim**	**Reimbursement Claim**
	(03) Estimated ☐	(09) Reimbursement ☐
	(04) Combined ☐	(10) Combined ☐
	(05) Amended ☐	(11) Amended ☐
Fiscal Year of Cost	(06) 20___/20___	(12) 19___/20___
Total Claimed Amount	(07)	(13)
Less: **10% Late Penalty, not to exceed $1,000**		(14)
Less: **Estimated Claim Payment Received**		(15)
Net Claimed Amount		(16)
Due from State	(08)	(17)
Due to State		(18)

(38) CERTIFICATION OF CLAIM

In accordance with the provisions of Government Code § 17561, I certify that I am the person authorized by the local agency to file claims with the State of California for costs mandated by Chapter 778/96, Statutes of 1996, and certify under penalty of perjury that I have not violated any of the provisions of Government Code Sections 1090 to 1096, inclusive.

I further certify that there was no application other than from the claimant, nor any grant or payment received, for reimbursement of costs claimed herein; and such costs are for a new program or increased level of services of an existing program mandated by Chapter 778, Statutes of 1996.

The amounts for Estimated Claim and/or Reimbursement Claim are hereby claimed from the State for payment of estimated and/or actual costs for the mandated program of Chapter 778, Statutes of 1996, set forth on the attached statements.

Signature of Authorized Representative _____ Date _____

Type or Print Name _____ Title _____

(39) Name of Contact Person for Claim _____ Telephone Number (_____) _____ _____ Ext. _____

E-mail Address _____

AMERICAN GOVERNMENT COURSE DOCUMENT REQUIREMENTS **Certification Claim Form** **Instructions**	**FORM FAM-27**

(01) Leave blank.

(02) A set of mailing labels with the claimant's I.D. number and address has been enclosed with the claiming instructions. The mailing labels are designed to speed processing and prevent common errors that delay payment. Affix a label in the space shown on form FAM-27. Cross out any errors and print the correct information on the label. Add any missing address items, except county of location and a person's name. If you did not receive labels, print or type your agency's mailing address.

(03) If filing an original estimated claim, enter an "X" in the box on line (03) Estimated.

(04) If filing an original estimated claim on behalf of districts within the county, enter an "X" in the box on line (04) Combined.

(05) If filing an amended or combined claim, enter an "X" in the box on line (05) Amended. Leave boxes (03) and (04) blank.

(06) Enter the fiscal year in which costs are to be incurred.

(07) Enter the amount of estimated claim. If the estimate exceeds the previous year's actual costs by more than 10%, complete form AGDR-1 and enter the amount from line (11).

(08) Enter the same amount as shown on line (07).

(09) If filing an original reimbursement claim, enter an "X" in the box on line (09) Reimbursement.

(10) If filing an original reimbursement claim on behalf of districts within the county, enter an "X" in the box on line (10) Combined.

(11) If filing an amended or a combined claim on behalf of districts within the county, enter an "X" in the box on line (11) Amended.

(12) Enter the fiscal year for which actual costs are being claimed. If actual costs for more than one fiscal year are being claimed, complete a separate form FAM-27 for each fiscal year.

(13) Enter the amount of reimbursement claim from form AGDR-1, line (11).

(14) Reimbursement claims must be filed by January 15 of the fiscal year in which costs are incurred or the claims shall be reduced by a late penalty. Enter either the product of multiplying line (13) by the factor 0.10 (10% penalty) or $1,000, whichever is less.

(15) If filing a reimbursement claim and have previously filed an estimated claim for the same fiscal year, enter the amount received for the estimated claim. Otherwise, enter a zero.

(16) Enter the result of subtracting line (14) and line (15) from line (13).

(17) If line (16) Net Claimed Amount is positive, enter that amount on line (17) Due from State.

(18) If line (16) Net Claimed Amount is negative, enter that amount in line (18) Due to State.

(19) to (21) Leave blank.

(22) to (37) Reimbursement Claim Data. Bring forward the cost information as specified on the left-hand column of lines (22) through (37) for the reimbursement claim [e.g. AGDR-1, (04)(1)(f), means the information is located on form AGDR-1, line (04)(1)(f)]. Enter the information on the same line but in the right-hand column. Cost information should be rounded to the nearest dollar, (i.e., no cents). Indirect costs percentage should be shown as a whole number and without the percent symbol (i.e., 7.548% should be shown as 8). Completion of this data block will expedite the payment process.

(38) Read the statement "Certification of Claim." If it is true, the claim must be dated, signed by the agency's authorized officer and must include the person's name and title, typed or printed. Claims cannot be paid unless accompanied by a signed certification.

(39) Enter the name, telephone number, and e-mail address of the person whom this office should contact if additional information is required.

SUBMIT A SIGNED ORIGINAL AND A COPY OF FORM FAM-27, AND A COPY OF ALL OTHER FORMS AND SUPPORTING DOCUMENTS TO:

Address, if delivered by U.S. Postal Service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
P.O. Box 942850
Sacramento, CA 94250

Address, if delivered by other delivery service:

OFFICE OF THE STATE CONTROLLER
ATTN: Local Reimbursements Section
Division of Accounting and Reporting
3301 C Street, Suite 500
Sacramento, CA 95816

9. Reimbursement Rates Effective 7/1/99, Unless Otherwise Specified

(a) Mileage:

The rate for the authorized use of a privately owned vehicle is 31 cents per mile.

(b) Meals/Incidentals

Meal expenses for breakfast, lunch, and dinner will be reimbursed in the amount of actual expenses up to the maximums. The term “incidentals” includes but is not limited to, expenses for laundry, cleaning and pressing of clothing, and fees and tips for services. It does not include taxicab fares, lodging taxes or the costs of telegrams or telephone calls.

Maximum Rate

Breakfast	$6.00
Lunch	10.00
Dinner	18.00
Incidentals	6.00

Actual lodging cost, with a receipt, of up to $79.00, plus applicable taxes is allowable. Effective November 2, 1999, actual lodging is up to $84, plus applicable taxes.

Effective November 2, 1999 through June 30, 2000, when employees are required to do business and obtain lodging in the counties of Alameda, San Mateo and Santa Clara, and Central and Western Los Angeles reimbursement will be for actual receipted lodging to a maximum of $110, plus applicable taxes. Central and Western Los Angeles is the territory bordered by Sunset Boulevard on the North, the Pacific Ocean on the West, Imperial Blvd/Freeway 105 on the South and Freeways 110, 10, and 101 on the east. This area includes downtown L.A., Inglewood, L.A. International Airport, Playa del Rey, Venice, Santa Monica, Brentwood, West L.A., Westwood Village, Culver City, Beverly Hills, Century City, West Hollywood and Hollywood.

(c) Parking:

Parking fees, without a receipt, is allowed for amounts equal to or less than $10.00.